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News for Members of the Ohio State Medical Association

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Health-care reform made law

HB 478 passes state Legislature

Photo by Jack Kustron

In Brief: HB 478 reforms health insurance and restricts Medicare balance billing.

House Bill 478, the long-awaited health-care reform legislation, passed both the Ohio House and Senate on December 17 and, at press time, was being prepared for the governor's signature. It will become law immediately upon signing by the governor.

This legislation focuses on health insurance reform and contains many provisions that received the full support of the OSMA. However, the legislation also contains two provisions that are of great concern to the association: It prohibits balance billing of lower income Medicare patients and it establishes two pilot projects that expand nurses' scope of practice. For detailed information on these provisions, see



Rep. Wayne Jones (D-Cuyahoga Falls) presents his case for the passage of HB 478.

separate articles below and on page 2.

"Working on this legislation has been a top priority for the associ-

ation this year," according to OSMA President Stanley J. Lucas,

See **HB 478** page 2

OSHA cites Ohio MD

In Brief: Compliance with OSHA's regulations on blood-borne pathogens means having a plan and following it.

An Ohio physician has been cited by the Occupational Safety and Health Administration for failure to comply with its blood-borne pathogen regulations, and has been fined \$26,000, the largest amount ever assessed a physician.

OSHA had originally cited

the physician in July when it made an office inspection based on an employee complaint. At that time, the fine was \$3,600, which was negotiated down to \$1,800.

"The physician told OSHA that he would comply, and he hired a consultant to help him develop a plan," says OSMA's director of Legal Services, Katrina English, JD.

A DO-IT-YOURSELF PLAN

With a consultant's help, the physician developed an informal compliance plan that consisted of a memo to his employees with a note explaining that they would no longer be permitted to perform procedures that exposed them to

See **OSHA** page 3

Balance billing law passes

A newly passed law (see story above) prohibits physicians from balance billing their Medicare patients with income at or below 600% of the federal poverty level (FPL). The 1991 FPL for a single person is \$6,620, making the limit \$39,720 for an individual.

This ban takes effect as soon as the bill is signed into law by the governor, which at press time was expected no later than the first week of January.

The law does not set up a system to assist the physician in determining which patients may

See **Billing** page 2

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MD, who points out that the OSMA made great strides in working with the state legislature to remove some very harsh restrictions on physicians that were included in earlier versions of the bill. For example, as originally introduced the bill proposed to: cap all physician rates at 110% of Medicare reimbursement; ban all balance billing; establish mandatory global hospital billing for physicians and freeze physician fees. See the chart on page 4 for a month-by-month description of the progress of the bill.

John Van Doorn, OSMA's director of Legislation, says that physicians should be particularly pleased with the removal of language to establish at first, global, then single hospital billing. All reference to these provisions were removed from the final version of the bill.

Van Doorn says it is important to keep in mind, however, that legislators view the successful passage of this bill as the first step in their efforts to reform health-care cost in Ohio. "In their eyes, HB 478 addresses the issue of health insurance reform. Next year, the focus will likely be on controlling health-care costs," Van Doorn predicts. For a breakdown of the legislative "movers and shakers" for 1993, see page 5.

Van Doorn points out, however, that an as-yet missing piece of the health-care reform puzzle is what steps the new Clinton Administration might take in addressing this issue at the national level.

INSURANCE REFORM

On the topic of health insurance reform, the newly passed legislation:

- requires health insurers to hold annual "open enrollment" periods of 30 consecutive days during which time insurers must accept a limited number of applicants, regardless of their health condition.
- restricts an insurers' ability to exclude persons with pre-existing medical conditions and assures that their health insurance is renewable.
- limits by 1996 insurers' administrative expenses to no more than 20% of total premiums collected.

- mandates that coverage for preventive care for children (birth to age 9) be included in every family health insurance policy.
- mandates that standard claims forms and standards for proof of loss be used by all health insurers and state health-care programs.

GENERAL REFORM

In addition, the bill:

- creates, but does not fund, the Ohio Children's Health-Care Program. This program would provide coverage to children whose parents are poor.
- sets up a system to collect data from public health programs on health-care costs that would be used for future health-care reform.
- establishes, but does not fund, a program to repay medical education costs for primary care physicians who work in designated underserved areas.
- prohibits physicians from referring their insured patients to clinical labs in which the physician or his or her family has a financial interest, unless the insurer agrees to the referral.
- requires hospitals, physicians and other health-care providers to pay a 15% reward to the patient and refund the overcharge, on any bill for health-care services that exceeds the usual, customary and reasonable fee by more than \$500.
- establishes a committee to study medical schools and make recommendations on how to retain Ohio graduates, how to increase the percentage of primary care physicians and how to improve distribution.

The OSMA will be providing members with additional information regarding the impact of this new legislation on their practices in the coming months. Members who would like to obtain a detailed analysis of the legislation may call the OSMA Department of Legislation at (800) 766-OSMA. ■

Pilot projects give nurses right to treat

An 11th hour push by the Ohio Nurses Association resulted in an amendment to HB 478 to establish two pilot projects that will give nurses the right to treat and prescribe in certain instances.

OSMA was able to stop the nurses from achieving their more ambitious original goal: independent practice and prescribing authority. This effort by the nurses follows close on the heels of an earlier, successful effort by optometrists to expand their authority to prescribe. The nurses' pilot project was vigorously opposed by the OSMA, but legislators insisted that the association negotiate with the ONA on this issue. The OSMA is hopeful that this proposal will slow down the nurses' cam-

paign to allow nurses throughout the state to practice independently.

Under the pilot project, advance nurse practitioners would be authorized to practice independently and prescribe some drugs at two inner-city health clinics in Cleveland and Dayton. These clinics would be run by the schools of nursing at Case Western Reserve and Wright State universities and would last for three years. Physicians will be involved in overseeing the programs and will be required to collaborate with each nurse who wishes to prescribe. The collaborating physician will designate which drugs the nurse may prescribe, choosing from a list of drugs that will not include Schedule I or II drugs. ■

Billing..*From page 1*

meet the income criteria. The OSMA is developing a form for physicians to use to certify income. Watch *OHIO Medicine* for further details.

Physicians who violate the law and balance bill exempt Medicare patients will, as a first offense, be publicly reprimanded and forced to repay the patient, plus be charged interest and a fine of \$500. Second and subsequent violations of the prohibition may carry a \$2,000 fine for each violation. Physicians may request a hearing before the Ohio Department of Health to defend against allegations that they violated the prohibition, but the losing party at this hearing may be assessed costs of up to \$25,000.

This new law only affects physicians who choose *not* to participate in the Medicare program. Participating physicians, by prior agreement with Medicare, cannot balance bill *any* Medicare patient (except for deductibles and co-pays). Under this new law, non-participating physicians will no longer be able to use the Medicare Annual Disclosure Reports (Fiscal Year 1993), which

contain the Limiting Charge Amounts to determine appropriate charges for Medicare beneficiaries.

Non-participating physicians will now have to determine an income for each Medicare beneficiary *before* a bill for health-care services or supplies is issued. If the Medicare beneficiary's income is below 600% of the federal poverty level, then the non-participating physician must accept the Medicare Allowed Amount (including applicable copayment) as payment in full. Participating physicians' reimbursement rate from Medicare is 5% higher than non-participating physicians.

The OSMA did a special mailing on December 17 to all OSMA members alerting them to this situation. Even though many physicians are opposed in principle to Medicare's par/non-par system, the OSMA felt it had a responsibility to let physicians know about the penalties and increased paperwork, in case it would prompt them to become a participating physician and avoid the hassles involved in this new law. The sign-up period to participate in 1993 ended on December 31, 1992. ■

Drunken-driving bill signed into law

Drunken drivers will have a more difficult time on Ohio's highways, now that Senate Bill 275 has been signed into law.

Any driver suspected of driving under the influence of drugs or alcohol must now submit to tests, and those who fail or refuse to take the tests will find their driver's licenses suspended on the spot.

The bill, sponsored by Sen. Paul Pfeifer (R-Bucyrus), also allows for impounding of cars when they are driven by someone:

- convicted of drunken driving twice or more within five years.
- whose license is already under suspension for drunken driving.
- who is not properly insured.

Those who have had their licenses taken by a law enforcement officer can appeal to a municipal court.

OSMA's policy is to support legislation that would require liquor establishments to post information on alcohol toxicity. ■

OSHA...From page 1

blood-borne pathogens. The physician, who works in a small office, had the time to do such procedures himself, and he decided to do all such procedures in the future.

MORE INFRACTIONS FOUND

OSHA, however, did not agree with the physician's do-it-yourself decision. At a surprise inspection in October, OSHA not only found further infractions of its regulations, for which it cited the physician, but it further penalized him for not putting into action the compliance plan OSHA required after the first inspection. His argument that he was performing such procedures himself did not excuse him from having and following a compliance plan, said the OSHA inspector.

The OSMA is presently working

AIDS disclosure bill needs more study

A bill that would have required physicians, dentists and nurses to report their HIV or HBV seropositive status to the Ohio State Medical Board, the Ohio Department of Health and their patients was significantly altered before passing the Ohio Legislature in November.

House Bill 419, the AIDS disclosure and reporting bill, had previously passed the Ohio House, but had stalled in the Senate.

In a last-minute move, Senate health committee chair Grace Drake (R-Solon) changed HB 419 so that physicians would not have to report their status. Instead, the bill now requires the Ohio Department of Health to form a panel to study the issue of transmission of HIV/HBV from health-care workers to patients. The ODH panel would then make recommendations that conform with CDC guidelines on this subject, and report back to the Legislature.

"We need responsible, proactive legislation on this issue," Sen. Drake told *OHIO Medicine*, "and in order to achieve that, we need to step back and evaluate what's

with legal staff members at the American Medical Association on how to proceed with this matter from here.

"The physician tells us that if he is forced by OSHA to pay the fine, he will have to quit his practice," says English.

TAKE REGULATIONS SERIOUSLY

She advises other physicians, whether they are in small or large practices, to take the OSHA regulations very seriously.

"You need a compliance plan, and you need to know what to do."

If you have questions regarding your office's compliance, either contact the appropriate OSHA area office, or call the OSMA's Department of Legal Services. ■

"We need responsible, proactive legislation on this issue."

— Sen. Grace Drake

already out there."

She points out that since HB 419 was introduced, the Centers for Disease Control disseminated its

guidelines on AIDS, which covered much of the material contained in the bill. Also, the Americans With Disabilities Act was passed, which could have an impact on future AIDS legislation. "These are federal laws and we have to be sure that any legislation is in concert with them."

The ODH panel will report back to the Legislature on October 1, 1993. At that time, new HIV legislation may be written. *OHIO Medicine* will keep you posted when and if that occurs. ■

Medical board's position

Despite the failure of House Bill 419 to pass the Legislature, the Ohio State Medical Board does have a position paper on this subject.

It requires physicians who test positive for HIV to report their condition to their colleagues, treating physician, and supervising member and secretary of

the board.

Confidentiality protocol is in place. If you have questions about this policy, contact OSMA's Department of Legal Services. (For further information on this topic, see "Legal Notes – AIDS" on page 16 in the Legal Section.

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The History of Health-Care Reform

A Look at the Progress of House Bill 478

| 1992 | Description | What's In | What's Out | What's New |
|-----------|---|--|---|--|
| January | HB 478, sponsored by Rep. Wayne Jones, and SB 240, sponsored by Sen. Bob Ney, are under consideration | <ul style="list-style-type: none"> • Medicare assignment • Reimbursement from all payors at 110% of Medicare • Ban on all balance billing • Mandatory global hospital billing | | <ul style="list-style-type: none"> • Well-child health insurance mandate • Physician fee freeze |
| February | HB 478 passes House | <ul style="list-style-type: none"> • Medicare assignment with financial means test at 700% of FPL • Standard insurance form • Immunity for physicians treating indigent patients • Well-child health insurance mandate | <ul style="list-style-type: none"> • Reimbursement from all payors at 110% of Medicare • Ban on all balance billing • Mandatory global hospital billing • Physician fee freeze | <ul style="list-style-type: none"> • OHIO plan to offer coverage to uninsured • 1% assessment on insurance premiums to fund OHIO plan • Physicians required to treat OHIO enrollees |
| March | HB 478 in Senate | | | <ul style="list-style-type: none"> • Repeal of prohibition against corporate practice of medicine |
| April | Senate disagrees with financing of OHIO plan | | | <ul style="list-style-type: none"> • Voluntary single hospital billing |
| May | New version drafted in Senate | <ul style="list-style-type: none"> • Repeal of prohibition against corporate practice of medicine • Voluntary single hospital billing | | <ul style="list-style-type: none"> • OHIO plan replaced by children's health-care program • Open enrollment for insurers |
| June | Senate passes HB 478 | <ul style="list-style-type: none"> • Mandatory Medicare assignment with means test at 550% of FPL • Voluntary single hospital billing • Children's health-care program • Open enrollment for insurers | <ul style="list-style-type: none"> • Repeal of prohibition against corporate practice of medicine • Immunity for physicians treating indigent patients • Well-child health insurance mandate | <ul style="list-style-type: none"> • Penalty for physicians promoting unnecessary care • Ohio center for health-care data • Medical student loan repayment program |
| July | Bill in joint House-Senate conference committee | | | |
| August | Conference committee continues to work on compromise | | | |
| September | Work continues on compromise | <ul style="list-style-type: none"> • Mandatory assignment • Voluntary single hospital billing | | <ul style="list-style-type: none"> • Commission to set statewide medical fees |
| October | Work continues | <ul style="list-style-type: none"> • Mandatory assignment • Voluntary single hospital billing • Children's health-care program | <ul style="list-style-type: none"> • Commission to set fees | <ul style="list-style-type: none"> • Provider tax • Independent practice for nurses at Cleveland and Dayton health clinics |
| November | Compromise nears | <ul style="list-style-type: none"> • Mandatory assignment • Voluntary single hospital billing • Children's health-care program | <ul style="list-style-type: none"> • Provider tax | |
| December | Final bill emerges (see related story on pages 1 and 2) | <ul style="list-style-type: none"> • Mandatory assignment with financial means test at 600% of FPL • Nurse independent practice • Children's health-care program • Medical student loan repayment program | <ul style="list-style-type: none"> • Voluntary single hospital billing • Penalty for physicians promoting unnecessary care | |

The Future of Health-Care Reform

Editor's Note: The chart at left details the progress of HB 478, the health-care reform bill that passed the Ohio Legislature in December '92 after a year of intensive debate. For more detailed information on the final version of HB 478, see the related article on page 1.

With this chart OHIO Medicine names 15 of the movers and shakers in the Ohio Legislature who are sure to influence the future of health-care reform in Ohio in 1993.

Sen. Robert W. Ney (R-Barnesville)



By sponsoring House Bill 478 in the Senate and chairing the Senate insurance committee where health-care reform bills

are debated, Ney has solidified his status as the leader on health-care reform in the Senate. He also has earned a reputation as a shrewd politician; Ney is a Republican who wins big in highly Democratic Belmont County.

Sen. Roy Ray (R-Akron)

A behind-the-scenes leader on health care, Ray serves on all the right Senate committees – health, insurance and the HB 478 conference committee – where health matters are decided. His quiet demeanor and unassuming style make him popular with his colleagues and effective at fashioning compromises when necessary.



Sen. Robert Nettle (D-Barberton)



Tabbed by the Senate Democrats as their sole appointment to the conference committee on HB 478, Nettle has emerged as their leader on health-care reform. He also serves on the Senate insurance committee.

Sen. Stanley J. Aronoff (R-Cincinnati)



His title as Senate president signifies that Aronoff is the leader of the Republican majority in the upper house. As the most powerful lawmaker in the Senate, he plays a key role on health-care legislation. He also has earned a national reputation as a skillful, well-connected leader of Ohio's interests.

Sen. Grace Drake (R-Solon)

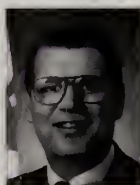


Chairing the Senate health committee, Drake controls the fate of many health-care bills. Drake is a strong supporter of physicians which

she demonstrated again last year when she cast the lone negative vote in her committee against the optometrists' prescribing bill.

Sen. Robert Boggs (D-Jefferson)

As leader of the minority Senate Democrats, Boggs may offer solutions to health care that are popular with the public but inimical to special interests like the OSMA. His goal is to create issues that can be used to help Democrats win in 1994.



Rep. Michael A. Fox (R-Hamilton)



Fox is the most visible House Republican on health-care reform and was the only member of that caucus to serve on the

HB 478 conference committee. While his Republican colleagues may sometimes wince at some of his ideas, they acknowledge that Fox is unparalleled in generating numerous proposals on health care.

Rep. Vern Riffe (D-Wheelersburg)



Speaker of the House of Representatives since 1974, Riffe controls all legislation that proceeds through the House. A moderate Democrat, Riffe has said that health-care reform is a national problem. He may wait to see what the Clinton Administration and Congress produce on health care.

Rep. Paul Jones (D-Ravenna)



As chair of the House health committee, he wields considerable power over many health-care issues. Jones also sponsors numerous health bills, including OSMA's 1987 medical liability reform and the children's health insurance mandate bill. He served on the HB 478 conference committee.

Rep. JoAnn Davidson (R-Reynoldsburg)



As the newly elected leader of the minority Republican House caucus, Davidson has her sights set on taking the Speaker's chair from Riffe in the '94 elections. House Republicans are likely to move quickly to offer a health-care reform bill.

Rep. Robert F. Hagan (D-Youngstown)



The author of a bill to establish a Canadian-style, single-payer system for health care in Ohio, Hagan is nationally recognized for his commitment to sweeping reform. A member of the House health committee, Hagan will be a force in the continuing debate on health-care reform.

Rep. Wayne Jones (D-Cuyahoga Falls)



As the chief architect of HB 478, Jones has emerged as the central figure in the House on health-care reform. A member of both the House health and insurance committees, Jones is knowledgeable on both health-care and insurance issues. His determination to achieve reform assures that he will continue to occupy the health-care spotlight.

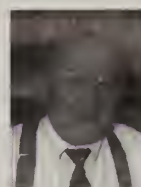
Rep. Mike Stinziano (D-Columbus)



He chairs the House insurance committee where changes in health insurance are decided. Though he did not serve on

the HB 478 conference committee, he is widely respected on insurance matters and will be a major player on reform in the future.

Rep. Dale VanVyven (R-Sharonville)



A frequent defender of physicians' interests on the House health and insurance committees, Van Vyven is a conservative who prefers free-market solutions to health reform and opposes expanding scopes of practice for limited health-care providers.

Rep. Raymond Sines (R-Perry)



The popular, young Sines is emerging as a leader on health-care reform for his House Republican caucus. He serves on the House health committee and sponsored his caucus' health reform bill last session.

A Year-End Report on State Legislation

On December 31, 1992, the curtain closed on the two-year session of the Ohio Legislature that began on January 1, 1991. Any bill that did not pass before year's end officially "dies" and must be reintroduced in the new legislative session that began January 1.

Below is a recap of the status of many bills of interest to physicians during the past two years.

Medical Board, HB 454

Advances the date for the biennial renewal of Ohio medical license and relaxes certain requirements for foreign medical graduates seeking licensure.

Status: Effective 4-30-92

Passed

Mammography, HB 142

Requires health insurance policies to provide coverage for mammography screenings and certain cytological screenings. Sets reimbursement at \$85 and prohibits balance billing (OSMA actively opposed a last-minute balance billing amendment).

Status: Effective 7-2-92

Passed

AIDS, HB 419

Requires the Ohio Department of Health to form a panel to study the issue of potential health-care professional-to-patient transmission of the HIV and HBV viruses, to make recommendations that conform with CDC guidelines, and to report back to the Legislature.

Status: Effective 3-15-93

Passed

EMS, SB 98

Creates a State Board of Emergency Medical Services to oversee training for emergency medical personnel. Also creates a state trauma registry system. OSMA effectively lobbied to gain physi-

Passed

cian representation of three of the 11 board members.

Status: Effective 11-12-92

Optometry, SB 110

Expands optometrists' scope of practice to include prescribing therapeutic drugs used in treating eye diseases.

Status: Effective 5-19-92

Passed

Tanning Parlors, SB 38

Would require periodic testing of tanning parlors and requires training for State Board of Cosmetology tanning parlor inspectors.

Status: Expected to be reintroduced

Failed

Antitrust Immunity for Hospitals, HB 714

Grants hospitals limited antitrust immunity for cooperative efforts aimed at reducing costs or improving access or quality of care.

Status: Effective 10-8-92

Passed

Physician-Patient Sex, HB 804

Disciplines physicians who engage in sexual conduct with a patient during the period in which the patient is under the physician's care.

Status: Expected to be reintroduced

Failed

Immunity From Liability, HB 469

Would grant physicians a qualified immunity from liability for voluntarily treating indigent patients in a charitable shelter or clinic.

Failed

Status: Expected to be reintroduced

Workers' Comp, SB 341

Would make comprehensive changes to Ohio's Workers' Compensation system. The OSMA has been working on the medical components of the bill, most notably on a provision that would recognize the OSMA as the negotiator with the bureau on medical issues.

Status: Expected to be reintroduced

Failed

Informed Consent for Abortions, HB 108

Establishes a protocol for obtaining informed consent for abortions. Requires physicians to provide women with specific information from the Ohio Department of Health on the risks of the procedure at least 24 hours before the abortion is performed.

Status: Effective 5-28-92

Passed

UHIO, HB 175

Would create the Universal Health Insurance of Ohio (UHIO) plan to provide every citizen of the state with basic health coverage. Modeled after the Canadian system, this bill would increase "sin taxes" and payroll taxes to pay for universal coverage.

Status: Expected to be reintroduced

Failed

Health-Care Reform, HB 478

Major health-care reform bill. For an update on the bill, see page 1. For a detailed history of the bill, see page 4.

Status: Passed General Assembly; awaiting governor's signature.

Passed

Living Wills, SB 1

Allows the execution of an advanced directive relating to the provision of, or withholding or withdrawal of life-sustaining treatment for a patient in a terminal condition, and makes changes in the Durable Power of Attorney for Health Care law.

Status: Effective 10-10-91

Passed

Preventive Care for Children, HB 169

Requires health insurance policies to provide coverage for preventive care for children from birth to age 18.

Status: Included in HB 478

Passed

Psychologists and Hospitals, HB 119

Prohibits hospitals from discriminating against psychologists when considering applications for membership, but does not grant admitting privileges.

Status: Effective 10-10-91

Passed

Steroids, HB 62

Establishes prohibitions against selling, offering for sale, prescribing, dispensing or administering anabolic steroids for purposes other than those approved under federal law.

Status: Effective 5-21-91

Passed

HMO, HB 259

Revises Ohio law governing health maintenance organizations (HMOs) by establishing certain regulatory standards.

Status: Effective 10-23-91

Passed

PRESIDENT'S PERSPECTIVES

Projecting a successful year

For 1993, your officers, Council and staff resolve full speed ahead in the effort to protect quality medical care, with emphasis on cost-effectiveness and access for all.

Continuing the December review of 1992 highlights by departments, it is noted that the **Legal Department**, under **Katrina English**, director, completed a comprehensive notebook of fact sheets on the most commonly asked legal questions; worked with the Ohio State Medical Board and the International Medical Graduate Task Force to successfully change licensure requirements for IMGs; filed several amicus curiae briefs and gave significant assistance to the executive staff during current litigation concerns.

Communications, under **Carol Mullinax**, director, developed and launched a highly successful domestic violence campaign; revamped *OHIO Medicine* into a more reader-friendly format;

developed a speaker's kit to assist physicians' participation in programs regarding health-care reform and topped off distribution of living will kits at more than 80,000.

Gail Dodson, director of **Education Services**, reported 70 management workshops, with about 2,400 in attendance; a successful Annual Meeting; and 26 facility surveys for continuing medical education accreditation.

Doug Evans, director of **Membership**, indicated an increase in the total number of dues-paying members, with 721 new physicians joining OSMA in 1991 and reported that membership retention is up for the first time in three years.

Kent Studebaker, director of **Medical Specialty Society Relations**, reported that he has increased the number of specialty societies that we provide management services to, from 13 to 17, and has helped strengthen the ties between the OSMA and state

specialty societies, especially with regard to socioeconomic issues.

Jim Wile, controller, reported a new, integrated accounting system.

The spirit of service and achievement demonstrated during 1992

by the directors and staff of the OSMA organization and their ambitious plans for 1993 are catalyzed by the effective leadership of **Brent Mulgrew**, executive director since July, and **Herbert Gillen**, senior director.

The OSMA staff deserves our applause. We have an award-winning team. To each and every one, a heartfelt thanks. OSMA is on the move. ■



Stanley J. Lucas, MD

News & Views

Does sex education work?

Sex education in schools is now a widely accepted practice. Presumably, this knowledge should decrease sexual activity and teenage pregnancies and improve contraceptive practices. But since there are now more than one million teenage pregnancies every year, such education doesn't seem to be doing the job we want. And making condoms available in schools is one idea I hate to hear!

W.B. Rogers, MD
Cuyahoga Falls

Do you have an opinion you'd like to share? Write to:

Editor, OHIO Medicine
1500 Lake Shore Dr.
Columbus, OH 43204-3824

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Brent Mulgrew
Director, Communications
Carol Wright Mullinax
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Associate Editor
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1500 Lake Shore Drive
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MATERNITY



AUXILIARY NEWS

Charting health care's destination

Recently, a friend returned from a trip to France. She and her husband planned this trip very carefully and had chosen to drive through the country in order to capture all the special spots and soak up the culture. Their itinerary allowed plenty of time for leisurely driving from point to point. They had this extended stay planned perfectly – or so they thought.

After several frustrating experiences of turning off on the wrong road, they finally figured out the system. The French would only put up a marker when a change in course was indicated. It's a "no news is good news" philosophy.

When we travel in this country, we are accustomed to seeing a highway marker every few miles, which lets us know that we are on the right road. The French system does make sense once you know

it; but for tourists accustomed to more highway signs, travel becomes challenging. You keep trusting that your destination is ahead of you somewhere, even though there's no sign that you

The roads may twist and the signs be hard to follow, but the destination has to be certain.

are going in the right direction.

Right now, the practice of medicine is a bit like the French highway sign system. There are few road markers leading to a destination. There's little comfort in not knowing where the next markers are and who will be

placing the markers. Just like my friends who returned from France, many words of frustration are exchanged because of the uncertainty.

Physicians and their spouses cannot trust that someone else is going to place the right sign up to chart the direction. A leisurely drive will not do. All must become actively involved in figuring out a solution to the complexities of the health-care delivery system. The road may twist and the signs be hard to follow, but the destination has to be certain – access to affordable health care. We cannot allow a "no news is good news" approach from ourselves.

March 10, 1993 is the day that Ohio auxiliarians have their opportunity to come to Columbus to make their voices heard about the

direction they want to see the practice of medicine go. "Communicating at the Capitol" is being

planned as an informational program as well as an empowering program to help one talk with their

representatives regarding health-care delivery in Ohio. The House and Senate health committees will be our luncheon guests. This is our opportunity to place a road marker and chart the destination. Please plan to attend this very important day in Columbus. ■



Sara Rich, President

LETTERS TO THE EDITOR

PICO sale questioned

To the Editor:

I wish to respond to the article concerning the "sell-out" suit by PICO shareholders against OSMA in the November issue. Not only were the responses by Dr. Stanley Lucas misleading, but blatantly incorrect. These false statements must be addressed to prevent yet another attempt at railroading by big businesses.

1. Medical Protective does *not* offer occurrence policies in the amounts required by most hospital boards. This is especially true in high-risk specialties, such as OB-Gyn.
2. PIE does not consider physician input in settling malpractice suits and does penalize the "right of appeal." Personal experience with PIE in a deep-pocket, "sue everyone" suit had a settlement made in a relatively small dollar amount without notifying the physicians involved. Only when they were questioned directly was the settlement and a vague dollar amount disclosed. But, when appealed, the PIE company chose to notify the physician that his policy would not be renewed less than one month prior to the renewal date. No reason was given to the local insurance agent on inquiry. PICO did not hesitate to supply the coverage needed at competitive rates.

Apparently, OSMA and PIE cannot be trusted anymore than can our

"people and education governor" George Voinovich!

Being currently retired on disability from a stroke, I can only wish the best to those who wish to stay with PICO, as I am not sure what will happen to the occurrence policyholders should PIE succeed. Money speaks, and that is probably why we, the physicians of Ohio, have heard no more of the return of the assessed stabilization funds, which will surely disappear if Ohio and OSMA complete the sale.

H. DAVID EVANS, MD
Salem

OSMA responds to member's concern

To the Editor:

This is in response to H. David Evans, MD's, Letter to the Editor regarding the proposed sale of OSMA controlling shares of stock in PICO to PIE Mutual Insurance Co.

The concern Dr. Evans voices about a continuing market for occurrence policies in Ohio should the proposed sale occur is valid. The OSMA Council, in considering this proposal, has the same concern. The Council was assured by PIE officials that PICO would continue to offer the occurrence form of professional liability coverage and that it (PIE) is in the process of developing a product for PICO that it believes is more advantageous for physicians than occurrence coverage because

LETTERS TO THE EDITOR

it will contain an annual reinstatement clause.

I would point out that PICO's primary competitor in marketing the occurrence form of coverage is not PIE but rather the Medical Protective Co., which recently announced higher liability limits on its policy, including Class III, which is the category for obstetricians.

The return of the Stabilization Reserve Fund has nothing to do with the proposed transaction. PIE, PICO, OSMA and others have worked hard to protect this fund for its rightful owners: the physicians, podiatrists and hospitals that paid into the fund. Hopefully, the process for the return of this fund will start in early January. The December issue of *OHIO Medicine* had a Page 1 detailed article on the status of the return of the fund.

STANLEY J. LUCAS, MD
OSMA President,
Cincinnati

PIE responds to allegations

To the Editor:

Thank you for the opportunity to respond to the comments of Dr. H. David Evans of Salem, Ohio. One of the more difficult tasks, which all insurance companies must deal with, is declining to accept a risk or, once having accepted the risk, declining to renew the coverage. It is true that PICO insures some doctors that PIE has declined to cover or failed to renew, just as it is true that PIE insures some doctors that PICO declined to cover or failed to renew.

We have examined our files with regard to the claim against Dr. Evans and the manner in which his nonrenewal was handled. Our files indicate the following:

1. The final decision regarding Dr. Evans' claim was made by a panel of physicians in Dr. Evans' specialty, and was made only after they received and reviewed Dr. Evans' written appeal of the panel's initial decision.
2. The Notice of Nonrenewal was sent to Dr. Evans substantially more than 30 days prior to the expiration of his policy.

It should be noted that the PIE Mutual Insurance Company is a not-for-profit Ohio corporation, which is owned by its member-insured physicians and dentists. All elected members of the Board of Directors of the PIE Mutual Insurance Company are physicians and dentists, and the company has no outside investors expecting to make a profit based upon a monetary investment in PIE.

We remain committed to provide our member-insureds with cost-effective professional liability insurance, including legal defense of unequaled excellence.

LARRY E. ROGERS
President and Chief Executive Officer, PIE Mutual,
Cleveland

Legislating ethics

To the Editor:

I read with interest the Viewpoint in the November *OHIO Medicine*. As chair of the ethics committee of the Franciscan Health System, I have dealt with problems relating to withdrawing and withholding of

medical treatments for the past four years. While the patient's self-determination issues are somewhat improved, the law causes problems because of vagueness of definition and mandated 12 months of maintenance for patients in PVS. Also, the law separates artificial nutrition and hydration from other medical treatment. This is contrary to almost all current ethical and legal trends. The main benefit of the law was legalizing and promoting the patient's determination of terminal care issues.

I have written numerous legislators with complaints about the law, and their only response is that they were forced to include objectionable issues by the Right to Life organization. It is sad when a PAC can thwart sensible legislation, and it speaks to the futility of attempting to legislate such issues when the local ethics committees and medical staff can and have dealt with them effectively. We would be glad to include the Right to Life organization persons at the local ethics committee level, but there does not seem to be anyone around who represents views as expressed or implied in the law.

Ethics and issues are continually changing, and we deal with them at the grass-roots level very effectively. Attempts to legislate such issues are counterproductive and impairs the evolution of such progress.

G. TERENCE REULAND, MD
Cincinnati

Discriminating ads

To the Editor:

I am writing this letter as the president of American College of International Physicians, Ohio Chapter, regarding a recent advertisement in *OHIO Medicine*. In this classified ad, the Riverside Methodist Hospital is seeking a full-time house position, and the requirements listed include: graduate of a U.S. accredited school of medicine with an Ohio license. It is ironic that this is the first *OHIO Medicine* issue that describes discrimination against international medical graduates. OSMA's IMG task force, of which I am a member, was told that this was an oversight on the part of the editorial staff.

Granted, it was an oversight, but the impact of such an ad on the international medical graduate community is profound and immense. It was this kind of reporting in the *AMNews* that made me discontinue my AMA membership, even though I was a member in good standing of that association for over 10 years. As a concerned OSMA international graduate member, and as the president of the Ohio Chapter of ACIP, I ask that the OSMA adopt a policy that prohibits such advertising in the future.

Such a strong response will surely bring more international medical graduates into the association, as it will ensure them that the OSMA is working to protect their interests, and working to abolish discrimination.

NIRANJAN N. PATEL, MD
President,
American College of International Physicians, Ohio Chapter,
Canfield

Editor's Note: *OHIO Medicine regrets that the classified ad was allowed to run with its original wording. Beginning this month, all ads will be screened for any sign of discrimination. We will also run a notice on our classified ad pages that says OHIO Medicine ads may not discriminate against race, gender or ethnic background.*



SECOND OPINION

Are you still saying "emergency room"?

Richard N. Nelson, MD

Few medical fields have matched the growth and development of emergency medicine over the past two decades.

Recognizing the unique knowledge base of emergency medicine, as well as the huge demands for emergency physicians (more than 90 million visits to U.S. emergency departments in '92), the American Medical Association and the American Board of Medical Specialties formally recognized emergency medicine as the 23rd medical specialty in 1979.

The modern emergency department (ED) bears little resemblance to the ER of earlier times. High technology facilities and equipment abound, designed to allow

emergency physicians and nurses the ability to treat virtually any type of emergency (and non-emergency). An incredible variety of problems, from major trauma to minor sore throats, are handled in emergency departments.

Many EDs have incorporated specialized area units and rape crisis centers, and many offer "fast track" areas to more efficiently handle the many non-emergency patients who utilize EDs.

No changes have been greater than that of the training and the scope of care of emergency physicians. The old standard of staffing the "ER" with inexperienced junior residents eager to undergo initiation by fire has long since passed. Under the guidance of organizations such as the Amer-

ican College of Emergency Physicians, a body of knowledge and standards of training were developed.

As a result, emergency physicians have greatly expanded their scope of care. They currently provide medical direction for most pre-hospital and aero-medical transport services as well as services in the ED.

In keeping with the expanded roles of emergency physicians and departments, the terminologies have changed. The term "Emergency Room" has been replaced by "Emergency Department." Similarly, the "ER doctor" is now an "emergency physician" and the specialty is emergency medicine.

Emergency physicians are proud to have contributed to the

vast improvement and expansion of emergency services over the past 20 years. Few states have benefited from this growth more than Ohio. One manner in which our colleagues in other medical specialties and professions, as well as the general public, can acknowledge the increasingly significant role of emergency medicine is by using the terms "emergency medicine," "emergency physician" and "emergency department" – terms that appropriately reflect the growth and complexity of our specialty.

Richard N. Nelson, MD, Columbus is President, Ohio Chapter of the American College of Emergency Physicians.



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AMA sets new policy on self-referrals

At its December meeting in Nashville, the American Medical Association's House of Delegates established policy that says physicians should not refer patients to labs and other facilities in which they have a financial interest. This same policy, recommended by the AMA's Council on Judicial and Ethical Affairs, was originally adopted by the House last December, but was changed at the June 1992 House of Delegates meeting to allow more referral.

The only exceptions to the new self-referral ban are:

- When a community needs a facility and only doctors who refer patients can finance them.
- When a facility is a direct extension of a physician's practice.

A Board of Trustees report on the negotiations issue was also adopted:

- That the AMA continue to pursue involvement in the development of health-care policy and regulations by the federal Medicare and Medicaid programs.
- That the AMA continue to lobby for legislation that will modify the antitrust laws to facilitate physician negotiation with managed care plans and for legislation requiring managed care plans to allow physicians to organize for the purpose of commenting on medical review criteria, and including the development of an AMA team to develop the information and networks of consultants necessary to assist



Annual Meeting participants

physicians in their interactions with managed care plans.

- That the AMA enhance activities in standard setting and enforcement, including the pursuit of protection from antitrust and tort liability necessary to facilitate self regulatory activities. ■

OSMA sponsors CME symposium

The OSMA Committee on Accreditation will sponsor its annual Symposium on Continuing Medical Education on Feb. 24-25 at the Ramada University Hotel and Conference Center in Columbus.

Learn the appropriate approach to preparing for a site visit, hear what surveyors look for when evaluating a program and find out what's on the horizon for CME in the computer field.

Physicians attending receive six hours of Category I CME credit. The registration fee is \$65 and should be received by Feb. 10.

For information contact Janet Orbaker, OSMA Department of Educational Services, (800) 766-OSMA. ■

Timetable for 1993 OSMA Annual Meeting

| Date | Time | Event |
|----------|----------|---|
| March 15 | | Deadline for resolutions. Must be submitted to OSMA, 1500 Lake Shore Dr., Columbus, OH 43204. |
| March 15 | | Nominations due for OSMA President- Elect. Claire Wolfe, MD, is the only candidate to date. |
| May 14 | 9 a.m. | Hospital Medical Staff Section Annual Meeting, Stouffer Tower City Plaza Hotel, Cleveland. |
| May 14 | 7 p.m. | First session of House of Delegates Stouffer Tower City Plaza Hotel, Cleveland. |
| May 14 | | Installation of Walter Reiling, MD, as OSMA President during first session of House of Delegates. |
| May 14 | | Presidential reception following first session of House of Delegates. |
| May 15 | 7 a.m. | OSMA Delegation to AMA Delegation Meeting |
| May 15 | 8 a.m. | Reference committees |
| May 15 | 2-5 p.m. | Candidate interviews |
| May 15 | 7 p.m. | OMPAC social event/dinner |
| May 16 | 10 a.m. | Final session of House of Delegates |

Members say third parties top concern

In Brief: OSMA's membership survey tries to determine the needs of new and old members so the association can better serve their needs.

Dealing with third-party payors is the most important challenge facing medicine today, say more than 100 new members, reaffiliates and general members of the Ohio State Medical Association.

In an ongoing survey, conducted by OSMA's Department of Membership throughout 1992, members are asked to rate OSMA services, and describe how the association can better meet member needs. "We're especially interested in surveying our newest members, because we want to make sure the association is meeting their needs, as well as those of our established members," says Doug Evans, director of Membership.

IMPORTANT SERVICES

When asked to rate the top challenges facing medicine, the majority of survey respondents have chosen the ever-intrusive relationship of third-party payors.

Most Frequently Used Services

1. OHIO Medicine
2. Medical Staff Bulletin
3. Physicians Guide to Ohio Law

Top Challenges Facing Medicine

1. Third-party payors
2. Legislative issues
3. Regulatory issues

Legislative and regulatory issues were not far behind, however – and while the OSMA has departments that specifically focus on all of these areas, it is the association's efforts on legal concerns that have drawn the highest praise from respondents (88%). Still, 58% thought the OSMA's efforts on legislative and regulatory issues were satisfactory; 42% favored efforts on third-party payor reimbursement; 30% on professional liability; and 29% on cost of health care.

As far as services provided for members, those most often considered very important include legislative representation, accred-

itation of hospitals for CME, the *Physicians Guide to Ohio Law*, media relations and assistance with third-party problems.

The most frequently used services were: *OHIO Medicine*, *Medical Staff Bulletin* and the *Physicians Guide to Ohio Law*. Of least interest to members were credit cards, medical/life insurance and car leasing.

Representing physicians in the Legislature ranked highest as an important objective of the association with 60%. It was followed by

protecting the rights of members (55%); communicating important issues of medicine (52%); and ensuring quality health care in legislation (52%). Promoting awareness of medicine and representing physicians' interests with third-party payors tied at 50%.

SPECIALTY GROUPS

The survey queried physicians to see what other organizations they belonged to. A large portion were members of their specialty

organization. When asked to compare the advantages of membership to a specialty society over the OSMA, respondents said the primary reason was that the specialty society addressed specialty-related issues and had a knowl-

edge of specific practice problems.

The OSMA Department of Membership will track the current trends to determine what changes may need to be made to better meet the needs of OSMA membership. ■

Most Important Services to OSMA Members

1. Legislative representation
2. Accreditation of hospitals for CME
3. *Physicians Guide to Ohio Law*
4. Media relations
5. Assistance with third-party problems

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October 10-13, 1993

Pediatric Infectious Disease Seminar
October 13-16, 1993

at Hilton Head Island, SC:

General Surgery Update
April 7-11, 1993

General Surgery Seminar
June 8-12, 1993

Adult Infectious Disease Seminar
June 15-19, 1993

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June 22-26, 1993

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July 13-17, 1993

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CALENDAR

The OSMA has planned the following practice management workshops for 1993. Watch for more information on these workshops in future issues of *OHIO Medicine*. Brochures will be mailed to OSMA members before each program.

Two Half-Day Workshops

Reception and Patient Flow Techniques – Designed to help anyone who may be involved with telephones and medical scheduling in a medical practice.

Better Collections, Billing and Insurance Techniques – Designed to improve the practice's results in dealing with the financial aspects of the medical office.

- Feb. 9 Concourse, Columbus
- Feb. 10 Holiday Inn – I-675 – Fairborn
- Feb. 11 Quality Hotel, Cincinnati
- Feb. 23 Hilton, Toledo
- Feb. 24 Sheraton, City Center, Cleveland
- Feb. 25 Parke Hotel, Canton

One-Day Workshop

Managed Care – You will learn the key strategies to profitably negotiate contracts and how to organize your practice to fulfill the contracts efficiently. This workshop will also give you a better understanding of the various delivery systems and payment mechanisms.

- Mar. 2 Marriott, Cincinnati
- Mar. 3 Holiday Inn, I-675, Fairborn
- Mar. 4 Concourse, Columbus
- Mar. 16 Hilton, Toledo
- Mar. 17 Sheraton, City Center, Cleveland
- Mar. 18 Parke Hotel, Canton

Medical Office Management Institute (MOMI)

These workshops have been designed for medical office managers, supervisors and key employees. Some offices have used these workshops to upgrade the skills of established personnel as well as for indoctrination of new employees. The following five-day workshops can be taken in any combination:

- effective personnel management techniques;
- improving your managerial effectiveness;
- patient flow management;
- financial management;
- improving your third-party reimbursement and coding

June 28-July 2, 1993 Cleveland Stouffer Tower City Plaza, Cleveland

August 2-6, 1993 Cincinnati Kings Island Inn, Kings Island, Ohio

OSMA forms insurance agency

OSMA members now have the opportunity to purchase insurance policies and other financial products for themselves, their family members and staff through the new OSMA Insurance Agency Inc. So far, more than 7,500 members and their staffs have taken advantage of the new plan.

Members will be able to choose insurance and financial products at a reasonable price.

The new agency will be managed by the Association Benefit Planners, an insurance and financial marketing firm headquartered in Columbus specializing in marketing and promotion of association member insurance benefits. ABP has been serving the association market in Ohio for more than a decade. Currently, it is endorsed by two other state medical associations and 14 county medical societies.

Herbert Gillen, senior director at OSMA, is president of OSMA Insurance Agency Inc., and Jerry Campbell, associate executive director of OSMA, is secretary of the agency.

"Since ABP will contract with a large variety of insurance and financial institutions, OSMA members will be able to choose insurance and financial products at a reasonable price from excellent carriers. OSMA will receive non-dues revenue in the form of commissions," says Campbell.

"We will provide OSMA members with insurance products that are of the highest quality," says Campbell.

Products available to members include: major medical plan, dental plan, IRA, group term life, personal financial profile, long-term care, single premium deferred annuities, guaranteed

investment fund, stock fund, bond fund, 10-year term, whole life, universal life, survivorship whole life and disability income. Some of the products will be provided by American Physicians Life Insurance Co. Other insurers include Lamar Life, Metropolitan Life and Provident Insurance.

BENEFITS TO MEMBERS

Members will benefit from the new insurance agency by receiving high-quality insurance products from the most appropriate insurance company; getting personal service; and receiving premium discounts.

This new member service will benefit OSMA by retaining and recruiting members and by generating more non-dues revenue.

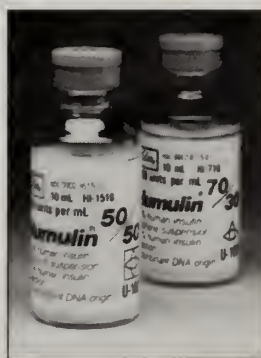
"All of the financial products will be competitively priced because ABP will be negotiating with the market for the best quality products and premium



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- Personal service
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| • Dental plan | • Stock fund |
| • IRA | • Bond fund |
| • Group term life | • 10-year term |
| • Personal financial profile | • Whole life |
| • Long-term care | • Universal life |
| • Single premium deferred annuities | • Survivorship whole life |
| | • Disability income |

discounts," says Campbell.

Those members who now have insurance products with the OSMA need not worry. Currently sponsored products, such as group-term life insurance started in 1958 and the major medical plan started in 1963, will be under

the auspices of the OSMA Insurance Agency Inc. and ABP.

OHIO Medicine will keep you posted on any new products and developments.

If interested in the OSMA insurance, please contact Association Benefit Planners, (800) 860-4525. ■

Athletes fitted with mouthguards

Protective mouthguards will be worn by all varsity basketball players in the Columbus public high schools during the 1992-1993 season by virtue of a combined project of the Academy of Medicine of Columbus and Franklin County, Columbus Dental Society, Columbus Health Department and the Columbus Public Schools.

Players were custom-fitted by volunteer dentists and provided a mouth protector for \$1.

A number of organizations have been working on this endeavor for the past year. "Coaches and parents must be made aware of the high potential for oral injury in sports, including basketball, which do not have mandatory mouth protector rules. This project will ensure that the players involved will have that protection," says Nancy Goorey, DDS,



Columbus Dental Society, Committee on Mouth Protectors.

The project was initiated after the highly successful production of the video, "Give Your Mouth a Sporting Chance," which was produced by the Columbus-based Council on Health Information, Ohio Dental Association, Ohio Osteopathic Association and the Ohio State Medical Association. ■

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Drug reviews may mean more phone calls for physicians

Physicians who treat Medicaid patients may receive more phone calls from pharmacists beginning this month.

The reason is OBRA '90, the federal budget reconciliation act, which requires states that want to keep their federal Medicaid funding intact to initiate a prospective drug utilization review system.

"The Ohio Department of Human Services has done retrospective drug utilization review for several years," says Deborah Bahnsen, JD, of the OSMA's Ombudsman Department.

Now, however, pharmacists are required to gather certain information before filling prescriptions for Medicaid patients (see sidebar for lists), and to provide patient counseling at the initial visit.

Pharmacists must offer to counsel Medicaid patients on correct dosage. This should mean that pharmacists will spend more time educating the patient about the prescribed medication.

NO SANCTIONS

Keep in mind, however, that this new fact-gathering is for educational purposes only; no one will be sanctioned or penalized for their prescription. "The goal is to ensure that patients are taking drugs properly," says Bahnsen. The information gathered by the state's pharmacists will be passed on to the Department of Human Services' drug utilization review board. The board, which will include four physicians, will use the information for establishing

criteria for the department's drug utilization review programs.

"The bulk of the compliance is on the pharmacist, not the physician," says Bahnsen, but she points out that physicians who prescribe for Medicaid patients may want to start adding some of the information the pharmacists

| Pharmacist Must Screen For: | |
|----------------------------------|-----------------------------|
| • Therapeutic duplication | • Incorrect dosage |
| • Drug-disease contraindications | • Drug allergy interactions |
| • Interactions with other drugs | • Clinical abuse or misuse |

need on the prescription.

"It may save them a phone call,"

Bahnsen says. ■

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What Pharmacists Must Ask For:

- Name, address, telephone number, date of birth, gender of patient
- Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices

Legal Notes

AIDS

Editor's Note: This is condensed from the OSMA's legal fact sheet notebook. Questions should be referred to the Department of Legal Services.

The Ohio Revised Code (ORC 3701.243) limits access to records regarding HIV testing or an AIDS diagnosis. Anyone who, while providing health-care services, learns the identity of an individual who was:

- tested for the HIV virus
- diagnosed as having AIDS
- diagnosed with an AIDS-related condition

cannot disclose the identity of the individual tested or diagnosed. However, there are several statutory exceptions to this confidentiality provision.

The individual's identity can be disclosed to the following:

1. The individual tested, his or her legal guardian, spouse or sexual partner.
2. A person authorized by a release, written by the individual tested (or his or her

legal guardian) specifying: to whom disclosure is authorized; and the time period in which the release is effective.

3. The individual's physician.
4. The Department of Health or a health commissioner to whom such reports are made.
5. A health-care facility or provider that procures or uses human body parts for organ donations and needs medical information ensuring the body part is medically acceptable.
6. Health-care facility staff committees, accreditation or oversight review organizations, conducting program monitoring, evaluation or service review.
7. A health-care provider, emergency worker or police officer exposed significantly to the

body fluids of a patient. The patient must first be asked to submit to an AIDS test. If the party refuses, then the infection control committee, or similar body in a health-care facility can be asked to rule whether or not a test should be conducted. If a test is done, the individual's name should **not** be revealed.

8. Law enforcement authorities with search warrants or subpoenas.
9. A health-care provider if he or she has a medical need to know the information and is participating in the diagnosis, care or treatment of the infected individual.
10. A federal, state or local government agency or an official representative (for purposes of the Medical Assistance program, the

Medicare program or any other public assistance program).

Disclosure to any of these individuals **must be made in writing** and accompanied by the following written statement (or similar language):

"This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses."

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Doctors still need 100 CME hours

Physicians are reminded that they must complete 100 hours of CME for this biennium (July '92 - July '94).

When HB 454 was passed last April, the medical board reduced the number of CME requirements from 100 hours to 75 hours for the initial biennium. At least 75 hours of CME had to be completed by September 30, 1992. Now, that deadline has passed, and with it the lower CME requirement. Once again, 100 hours of CME are needed in order to maintain your license.

If you have questions, contact the Ohio State Medical Board, (614) 466-3934 or OSMA's Department of Legal Services, (800) 766-OSMA. ■



ODI completes PICO/PIE hearing

The Ohio Department of Insurance recently completed a two-day hearing regarding PIE Mutual Insurance Company's proposed plan to purchase OSMA's controlling stock in the Physician's Insurance Company of Ohio.

This hearing is a first of a series that PIE must go through before it can purchase OSMA's Class B shares of PICO.

During the hearing, representatives of both PIE and PICO presented expert testimony regarding the impact of the proposed sale on the cost and availability of professional liability insurance in Ohio.

PIE's expert economist contended that the proposed sale would not give PIE a monopoly over the state's professional liability insurance market since there are numerous opportunities for other carriers to enter the market.

In addition, Larry Rogers, president of PIE, testified that, should the transaction be approved:

- He intends to maintain both PICO and PIE as separate providers of liability insurance and would continue the consent-to-settle provisions in PICO policies;
- He would continue to offer occurrence coverage through PICO.
- He would use PIE's buying power to negotiate more favorable reinsurance agreements.
- He does not have any plans to acquire PICO's Class A shares or to liquidate the assets of the company.

In other testimony, Edwin Seasons, MD, a Bexley physician who owns a considerable number of Class A PICO shares, stated that he favors PIE's acquisition of PICO shares because a rapid close of the transaction will cause the value of the Class A shares to stabilize. The information gathered at the hearing will be used by the director of insurance to make a determination on whether PIE will go forward with its plan to

purchase the OSMA Class B shares in PICO. The ODI decision is not expected until sometime this month. ■

Late-breaking news on PICO/PIE

The antitrust action filed in federal court by PICO to stop the proposed sale of OSMA's PICO stock to PIE Mutual Insurance Company has been dismissed.

The judge issued the opinion on Dec. 18, stating that PICO does not have sufficient grounds for bringing the antitrust action.

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A medical records primer

Medical records is the topic of the questions most frequently asked of OSMA's Department of Legal Services. How long is it necessary to keep records, what should they contain, and who has the ownership rights to them?

The department has developed responses to these and other common questions pertaining to medical records. This will be the first of a series of short articles addressing this topic.

PATIENT ACCESS TO RECORDS

When consumers call the OSMA to register complaints about their physicians, they are often upset because a physician has refused to provide access to medical records. Ohio law does not address patient access to records kept by a private physician. (There is a law requiring hospitals to provide patients access to their records upon request). However, the state medical board can discipline physicians for violations of AMA ethical principles. The AMA's Council on Ethical and Judicial Affairs has stated the following:

A physician who formerly treated a patient should not refuse for any reason to make records of

that patient promptly available on request to another physician presently treating the patient. Proper authorization for the use of records must be granted by the patient. Medical records should not be withheld because of an unpaid bill for medical services (CEJA Opinion 7.01).

Notes made in treating a patient are primarily for the physician's own use and constitute his or her personal property. However, on request of the patient, a physician should provide a copy or a summary of the record to the patient or another physician, an attorney or another person designated by the patient (CEJA Opinion 7.02).

Upon patient request, physicians should provide copies or summaries of records to the patient, another physician, or any other person designated by the patient. However, in the case of mental health records, a patient has access to his or her own psychiatric and medical records only if access is not specifically restricted in the patient's treatment plan [R.C. 5122.32(E)].

OBTAINING CONSENT

Prior to releasing any copy, the

physician should get the patient's written consent. The physician should examine the consent to assure that the signature is authentic and is by a person of the age of majority (18 in Ohio) or by his or her guardian or other legal representative. The consent must cover the release of the documents requested. Only the information specifically requested should be released. The signed consent form should also state to whom the information is to be revealed. The original records should be re-

tained by the physician.

It is important to remember that medical records are confidential and should only be released upon receipt of the patient's written consent. A reasonable fee may be charged to cover the cost of copying records or producing a summary of the records.

For specific questions, or to receive a fact sheet on medical records, call OSMA's Department of Legal Services at (800) 766-OSMA. ■

Update

Private contracts

A U.S. District Court in New Jersey has ruled that there is no prohibition in Medicare against private contracting, and that the Secretary of Health and Human Services has no clearly articulated policy that forbids such contracting (*Stewart v. Sullivan*). Physicians who now make private contracts with patients may still be challenged by HCFA. Patients who agree to disenroll from Medicare cannot submit a bill to Medicare. If Medicare is billed, the physician is in trouble.

CLIA case

Four physicians have filed suit in the U.S. District Court for the Northern District of Florida, charging that HHS regulations under the Clinical Laboratory Improvement Act of 1988 is "arbitrary and capricious" in categorizing tests qualified for a waiver, and that it failed to comply with administrative law requirements for notice and comment. Plaintiffs have asked the court to enjoin HHS from enforcing the regulation that excludes certain tests from the list of waived tests.

Arrest ordered

The Ohio Supreme Court has upheld a lower court's order to arrest self-described "love doctor" James C. Burt, MD, for violating an order against talking to the media in 1991. Dr. Burt, now living in Florida,

discussed the case in which an ex-patient is suing him for medical malpractice with a Dayton television station. Although he was in California at the time, the Supreme Court ruled that Dr. Burt's action would be "contemptuous no matter where it was done." Florida is not expected to serve the civil warrant, but Ohio could place him under arrest if he returns to the state.

License suspended

A Dayton-area physician who placed 200 milligrams of Benadryl and a prescription tranquilizer into the feeding tube of a nursing home patient, which subsequently clogged the tube and set off an alarm, has had his license suspended indefinitely by the Ohio State Medical Board. His license can be reinstated by meeting certain conditions.

Case goes to trial

Sabry Awadalla, MD, Ravenna, who was removed as a department head at Robinson Memorial Hospital, is headed for his third trial in an effort to be reinstated. Originally, the anesthesiologist charged that the hospital violated medical staff bylaws; violated the sunshine law; and charged that his removal was unreasonable and arbitrary. Portage County Common Pleas Court dismissed the charges, but the 11th District Court of Appeals found in his favor. The Ohio Supreme Court refused to hear the case, so it will return to the original trial level.

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LCERs spot Medicare billing errors

Nationwide-Medicare will continue to mail, on a biweekly basis, Limiting Charge Exception Reports (LCERs) to nonparticipating physicians who, according to Medicare's files, have exceeded their limiting charge amounts on nonassigned claims. The LCER identifies claims data information for charges that have exceeded the physicians limiting charge amount by \$5 or more on claims filed during the two-week report period.

The LCER is designed to be informative, rather than punitive, and because the reports are issued every two weeks, physicians will be advised promptly when excesses do occur so that corrective action may be taken on not only the identified claims, but on future claims submissions.

Because only the patient is informed on nonassigned claims of Medicare's claims payment determinations, physicians may be unaware that they are charging more than their limiting charges. Following are a few common carrier interventions that may cause charges to be excessive:

- **Downcoding of Services** – When Medicare determines that the documentation provided does not substantiate the level of service billed (e.g., 99215), it may reduce the procedure to a lesser level (e.g., 99213), and no adjustment is made to the limiting charge.
- **Rebundling of Services** – When procedures are billed separately that are a part of HCFA's mandatory bundling of surgery procedures, Medicare will rebundle all of the procedures into the major service and combine the separate charges.
- **Multiple Surgical Procedures** – When billing for multiple procedures, physicians may charge the full limiting charge amount on *only* the first (primary) procedure. The limiting charge for the second,

third and subsequent procedures must be reduced.

Physicians are advised to carefully review the LCER to ensure

that the overcharges are not the result of errors, specifically data-entry errors.

The new monitoring program requires that Medicare must also inform the patient about potential excessive charges. If you have questions, contact the Ombudsman staff at (800) 766-OSMA. ■

BWC proposes par program

The Ohio Bureau of Workers' Compensation is proposing rules to establish a provider participation program for fee bills sub-

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THIRD-PARTY UPDATE

mitted to the bureau. A participation program would require providers (including physicians) to sign a contract with BWC in order to be paid directly by the bureau. In addition, by signing the participating contract, the physician would be required to accept BWC's payment as payment in full.

The OSMA's Task Force on Workers' Compensation recently reviewed a draft copy of the BWC participating provider agreement and identified several areas of concern with the agreement in-

cluding such elements as lack of an appeals process for disputed reimbursements, duration of the contract, mechanism for withdrawal of the contract, and BWC reimbursement levels.

The task force is directing a letter to BWC expressing these concerns. ■

If you have any questions about any story in the Third-Party Update section, contact the OSMA Ombudsman staff at (800) 766-OSMA.



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PRS seeks physicians to fill 4 positions

Peer Review Systems, Inc. (PRS), Ohio's Peer Review Organization, is seeking one full-time physician principal clinical coordinator, two part-time (20 hours per week) assistant clinical coordinators, and one part-time (20 hours per week) medical director.

Minimum qualifications for all positions require graduation from an approved school of medicine/osteopathy and current Ohio

licensure. Additional qualifications for each position may be obtained by contacting PRS.

Interested candidates may contact PRS at (614) 895-9900 or send a resume/CV with salary expectations to: Ken Kunkleman, Peer Review Systems, 757 Brookside Plaza Drive, P.O. Box 6174, Westerville, Ohio 43081-6174. ■

Update

PRO names new med director

Grant K. Varian, MD, Bellefontaine, is Peer Review System Inc.'s new corporate medical director. He is a former Peer Review Systems Board of Trustees member and a past president of the Logan County Medical Society. Dr. Varian will oversee all physician review of health care provided to Medicare recipients.

HMO bought

United HealthCare Corp. of Minnetonka, Minnesota has recently acquired its second Ohio HMO. Its first purchase was the Physicians Health Plan, located in Columbus. Now, the group has purchased Western Ohio Health Care Corp. of Dayton, 95% of which is owned by physicians. Approximately 1,700 physicians, 70% of the doctors in the greater Dayton area, are under contract to Western Ohio. United HealthCare Corp. will now own nine HMOs. It currently manages 10 HMOs.

Coding delay

The Clinical Laboratory services from the 1993 Current Procedural Terminology (CPT) will not be implemented by Medicare and Medicaid until **April 1, 1993**, when the Health Care Financing Administration (HCFA) revises the 1993 laboratory fee schedule. Physicians must use the 1992 CPT codes for

services between Jan. 1, 1993-March 31, 1993. Also, for Medicaid, physicians performing obstetrical services should continue to use CPT code 59420 for each antepartum visit provided.

CLIA extends grace period

HCFA is allowing a continuation of the December 1 grace period for CLIA certification. The grace period is expected to end in early 1993. Medicare carriers are to notify physicians if records do not indicate a CLIA number is on file. Physicians will then have three options: request and return the HCFA 109 registration form, notify the carrier that its records are in error by providing the carrier with the registration number, or stop performing all laboratory tests.

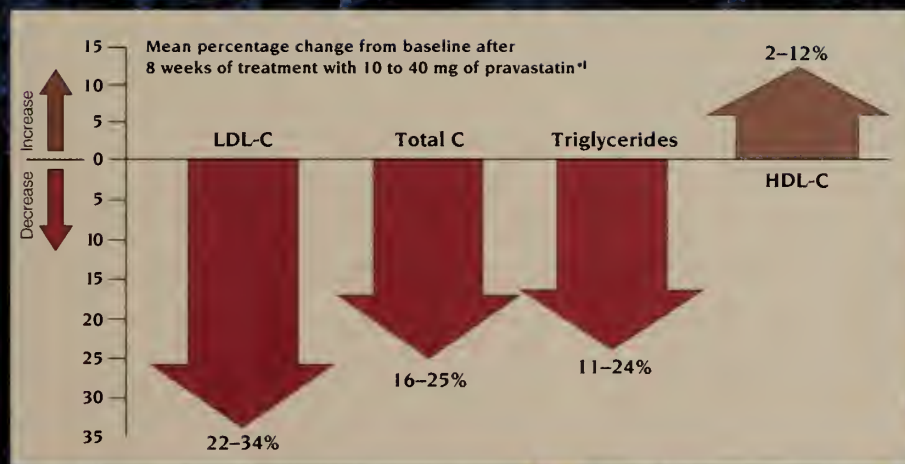
Thermography coverage withdrawn

As announced in the Nov. 20, 1992 *Federal Register* HCFA has withdrawn Medicare coverage of thermography for all indications. Thermography is the measurement of self-emanating infrared radiation that reveals temperature variation at the surface of the body. According to the final rule, evidence indicates that thermography is not effective in diagnosing or treating illness or injury.



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[†]Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol*. 1991;14:146-151.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



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Ohio may offer public health class

Despite Ohio's seven medical schools, there isn't a single program in the state that teaches public health. Representatives

from the Ohio State University, Case Western Reserve University and the University of Cincinnati's medical schools have all lobbied for a public health school, but it is Case Western Reserve, in conjunction with Cleveland's Metro-Health Medical Center, that has taken the first tentative step in that direction.

Epidemiology and biostatistics, environmental health sciences and the center for biomedical ethics will move this year from CWRU to MetroHealth, where an expanded program in public health will be offered. A master's degree program in public health may follow. ■

PRAVACHOL® (Pravastatin Sodium Tablets) CONTRAINDICATIONS

Hypersensitivity to any component of this medication.
As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Warnings: Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the group receiving pravastatin monotherapy. Myopathy was not reported in the trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when difelrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when difelrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia: Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency: A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3 α -hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t_{1/2}) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin: See WARNINGS: Skeletal Muscle.

Antipyrene: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent and abundant in pre-menopausal females are unknown) after the plasma protein-binding of warfarin. Concomitant dosing did not increase the AUC and C_{max} of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC_{0-12h} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, C_{max}, and T_{max} for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with aspirin, antacids (1 hour prior to PRAVACHOL), cimetidine, nicotinic acid, or probucol, no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels; and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p<0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a \geq 50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spiroclonolone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

Update

AIDS redefined

The Centers for Disease Control has added pulmonary tuberculosis, recurrent pneumonia and invasive cervical cancer to the list of diseases that indicate AIDS has fully developed in HIV-infected individuals. These three bring the total number of AIDS indicator diseases to 26. The revised definition went into effect January 1.

Hepatitis A

Hamilton County is reporting an almost seven-fold increase in Hepatitis A cases over the past two years, and Cincinnati, alone, has more cases than all of Kentucky. The Queen City doubled the number of cases it reported last year, 136 up from 63. Kentucky reported 75 cases in 1991, and Ohio reported a total of 324.

Fish tested for chemicals

The Ohio Department of Natural Resources will conduct a two-year study to determine whether or not most Lake Erie fish species are safe to eat. Historically, Lake Erie fish have had lower contaminant levels than fish taken from other Great Lakes. Walleye, yellow perch and other fish will be caught and examined for chemical contaminants.

Half of children not properly immunized

A significant number of doctors don't give immunizations to children who are breast-fed, were born prematurely, have or are recovering from a minor illness, says Thomas Halpin, MD, chief of preventive medicine for the Ohio Department of Health. Yet, in most instances, these children could be immunized. "The problem is, once you turn them away, they may not come back," says Dr. Halpin. According to health experts, about one in every two children, age two and under in Ohio, have not been adequately immunized.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinoganglionic fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear (Wallerian-like) degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p<0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p<0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests using *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/– mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Adverse Effects: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: General.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

| Body System/Event | All Events % | | Events Attributed to Study Drug % | |
|---------------------|---------------------|-----------------|-----------------------------------|-----------------|
| | Pravastatin (N=900) | Placebo (N=411) | Pravastatin (N=900) | Placebo (N=411) |
| Cardiovascular | | | | |
| Cardiac Chest Pain | 4.0 | 3.4 | 0.1 | 0.0 |
| Dermatologic | | | | |
| Rash | 4.0* | 1.1 | 1.3 | 0.9 |
| Gastrointestinal | | | | |
| Nausea/Vomiting | 7.3 | 7.1 | 2.9 | 3.4 |
| Diarrhea | 6.2 | 5.6 | 2.0 | 1.9 |
| Abdominal Pain | 5.4 | 6.9 | 2.0 | 3.9 |
| Constipation | 4.0 | 7.1 | 2.4 | 5.1 |
| Flatulence | 3.3 | 3.6 | 2.7 | 3.4 |
| Heartburn | 2.9 | 1.9 | 2.0 | 0.7 |
| General | | | | |
| Fatigue | 3.8 | 3.4 | 1.9 | 1.0 |
| Chest Pain | 3.7 | 1.9 | 0.3 | 0.2 |
| Influenza | 2.4* | 0.7 | 0.0 | 0.0 |
| Musculoskeletal | | | | |
| Localized Pain | 10.0 | 9.0 | 1.4 | 1.5 |
| Myalgia | 2.7 | 1.0 | 0.6 | 0.0 |
| Nervous System | | | | |
| Headache | 6.2 | 3.9 | 1.7* | 0.2 |
| Dizziness | 3.3 | 3.2 | 1.0 | 0.5 |
| Renal/Genitourinary | | | | |
| Urinary Abnormality | 2.4 | 2.9 | 0.7 | 1.2 |
| Respiratory | | | | |
| Common Cold | 7.0 | 6.3 | 0.0 | 0.0 |
| Rhinitis | 4.0 | 4.1 | 0.1 | 0.0 |
| Cough | 2.6 | 1.7 | 0.1 | 0.0 |

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.
Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required. (J4-4222A)



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Health care straining state's budget

In Brief: *Medicaid and an aging population has forced the state to do "more with less." Now it's Ohioans' turn.*

At the Statehouse, legislators have been wrangling for some way to finance expanded health-care for the state's needy children. Meanwhile, R. Gregory Browning, director of Ohio's Office of Budget and Management, is struggling to keep Medicaid coffers up with the growth in the current Medicaid program.

MEDICAID IS LARGEST EXPENSE

"Medicaid is the largest line item in the state budget," says Browning, who recently spoke at a day-long seminar, presented by the Commission on Interprofessional Education and Practice, and sponsored, in part, by the Ohio State Medical Association. "A dozen years ago, education would have been our largest expense. Now, it's Medicaid. Medicaid is the PacMan of state budgets, gobbling up more and more revenues so we are forced to invest more and more dollars in health care."

Adding to the strain is a 600% increase over the past 13 years in Medicaid spending for services for the aging, since more Ohioans are living longer and requiring additional help. Says Browning: "It's a sign of the times. This is where our future spending will go."

The problem, of course, is that the state has limited resources to meet its obligations. According to Browning, the state's budget stabilization fund, the "rainy-day account" that serves as a buffer in bad times, contains only 14 cents.

"The bad times have come, and we've had to take the money to meet our obligations. Even when an economy suffers, the state can't stop spending," the budget director explains.

There are three possible solutions to the state's budget crunch: raise taxes, cut spending, or both.

Spending has already been reduced as much as possible in each state agency, says Browning. "We've trimmed about \$600 million." The next step, then, is to raise taxes, and Browning hints that Gov. George V. Voinovich may look toward a one-cent raise in the state sales tax in the not-too-distant future. Also under discussion is expanding sales tax to certain types of services (eg. club memberships, medical lab fees) and increasing the income tax on those in higher income brackets.

NEED FOR INVESTMENT

"Polls have indicated that the American people are in favor of taxes, if it's for a reasonable cause and not for the same inefficiencies. Citizens don't want business as usual. The public wants measurable results," says Browning. "They want to buy something, but

they want to know, first, 'what will we get for our money?'"

Browning says the governor's "more with less" philosophy has forced state agencies to shift to a more integrated approach over the

past few years so there is more "bang for the buck."

Fixing this malaise is a function of both state and federal governments – and ultimately the taxpayers who fund them. ■

Browning Says

R. Gregory Browning, director of the State Office of Budget and Management, recently made the following observations on health care:

Medicaid... "The PacMan of state budgets, gobbling up more and more revenues."

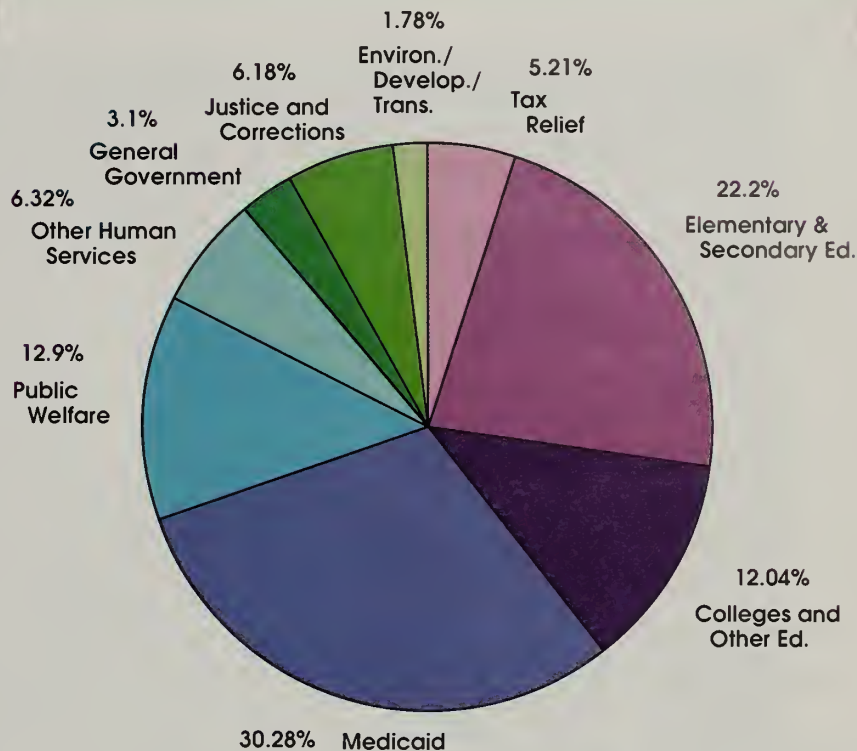
Rationing... "I would have let Oregon conduct their experimental plan. We're rationing irrationally now, along economic lines."

Universal health care... "We want to slowly expand benefits, taking a building-block approach to get everyone under health-care's umbrella."

Global billing... "There are professional 'games-men' who teach how to bundle and rebundle fees to get more money. That's why there should be global billing."

General Revenue Fund Appropriations Fiscal Year 1993

Total Appropriations – \$14,278.3 Million*



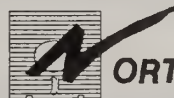
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Ohio's new need for physicians

Does Ohio need more physicians? A recent survey conducted by the Northeastern Ohio Universities College of Medicine seems to indicate that more physicians will be needed in the future, as those who are currently in practice choose to retire or devote less time per year to professional activities.

The study concluded that more physicians will be needed by 2001 just to deliver the *same quantity* of professional time as was delivered in 1991 – and that doesn't begin to count the increased demands for services that may accompany population growth and aging.

PRIMARY CARE SHORTFALL

Meanwhile, Ohio's medical

schools have noticed a shortfall in the number of students enrolled in primary care fields, so the Council of Medical Deans has unveiled a plan that aims to have 50% of the state's medical school graduates enter primary-care fields. Last year, about 40% of graduates from the state's seven medical schools chose primary-care areas.

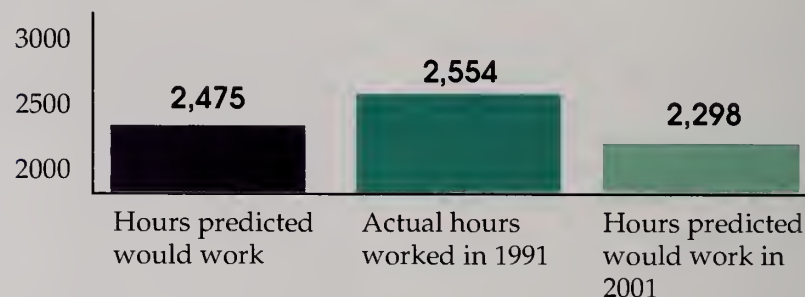
The council has set the following goals to help stop the shortage:

- increase the number of medical school applicants who are likely to choose primary care.
- encourage recruiting medical students from underserved areas and populations.
- create financial incentives to

Physicians Expected To Work Less In 2001

In 1986, the Northeastern Ohio Universities College of Medicine asked physicians to predict the average number of hours they would spend in professional activities per year.

The chart below shows the hours projected against the actual hours worked, and from a recent survey, a projection for the number of hours Ohio physicians expect to work in 2001.



*As a guide, working 40 hours a week 50 weeks a year equals 2,000 hours.

encourage more medical students to enter primary care.

- develop additional academy primary-care practice sites

separate from hospitals, staffed by faculty role models and support clinical education that encourages students to consider entering primary-care practice. ■

Cancer drug treating soft-tissue sarcomas

Last January, *OHIO Medicine* reported that a new anti-cancer drug, taxol, was showing promising results in fighting advanced cases of ovarian and breast cancers. Now, physicians at Ohio State University's Arthur G. James

Cancer Hospital and Research Institute are testing the drug on patients with soft-tissue sarcomas.

According to Stanley Balcerzak, MD, head of the sarcoma committee of the Southwest Oncology Group, early testing is very

encouraging. Taxol showed more activity against tumor cells than the best drug currently being used for treating soft-tissue sarcomas.

Research, however, also shows that taxol will be more effective when it is used earlier in the

course of the disease and when it is combined with other drugs.

OTHER NEW TREATMENTS

Two other new treatments are being tested at the James Cancer Hospital:

- 1.) MAID (Mesna Adriamycin Ifosfamide Dacarbazine). This will be used on patients with advanced stage sarcomas and relatively large (more than five cubic centimeters), rapidly growing tumors. Already, MAID has been up to twice as effective as previous treatments for sarcoma patients.
- 2.) Alternating combinations of drugs prior to surgery for patients with osteosarcomas. This type of treatment indicates it can kill 90% of the tumor prior to surgery.

For more information about these clinical trials contact Dr. Balcerzak at (614) 293-8729 or the James Cancer Hospital at 1-(800) 638-6996. ■

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Richland Memorial Hospital in Columbia, South Carolina, designates this activity as meeting the criteria for 15 hours of continuing medical education credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

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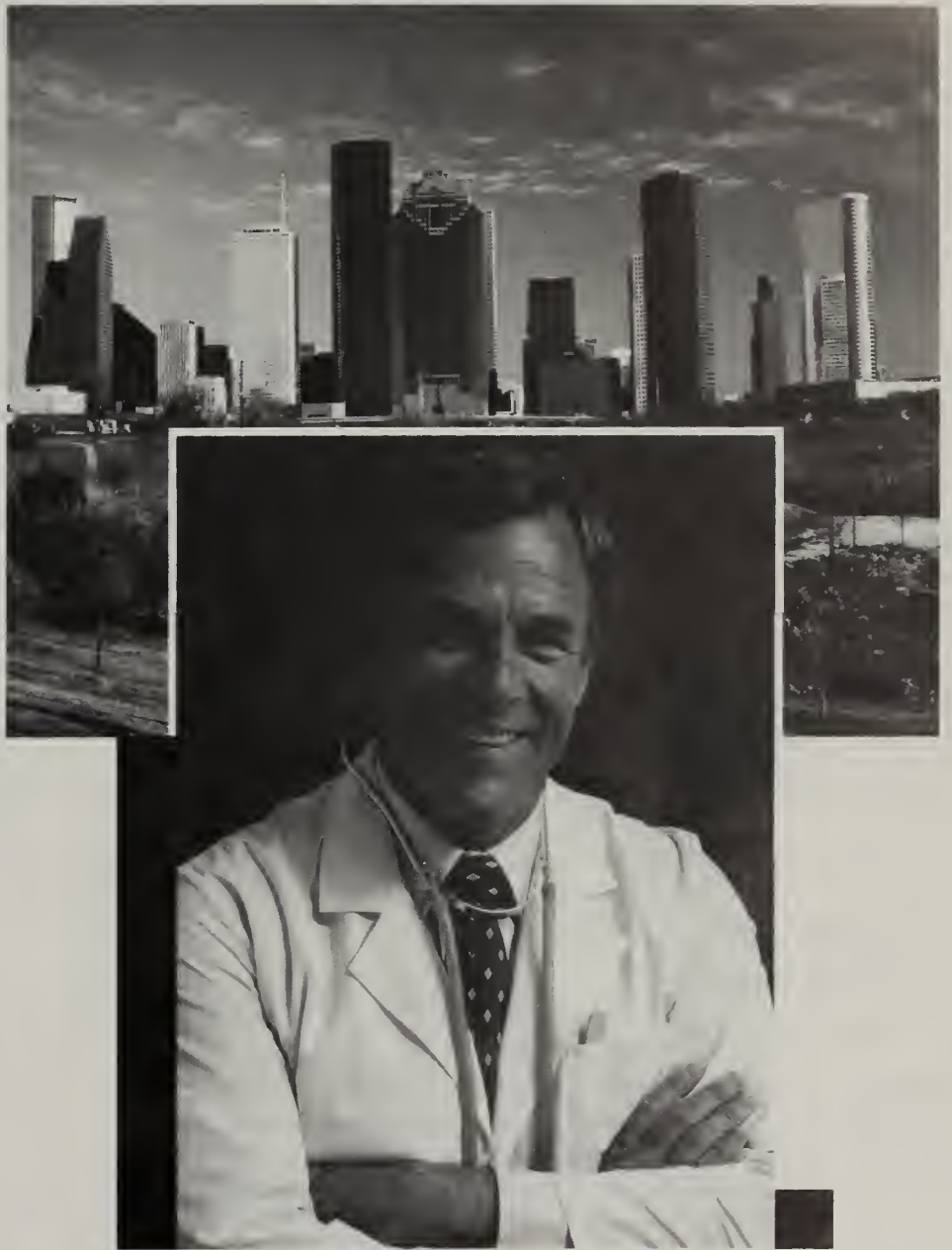
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Survey Winners

OHIO Medicine is pleased to announce that Robinson Kirkpatrick, MD was the first-place winner for answering our readership survey. Dr. Kirkpatrick, of McConnelsville, was awarded \$100. Second prize of \$75 went to L. Jill Tibbe, MD, of West Carrollton, and third prize of \$50 went to John Edward Hohmann, MD, of Pataskala.

Results of that survey will be printed in next month's issue.

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OBITUARIES

WALTER E. FENING, MD, Middletown; University of Cincinnati College of Medicine, 1944; age 72; died September 7, 1992; member OSMA.

KENNETH J. FRANKS, MD, Senecaville; University of Cincinnati College of Medicine, 1948; age 69; died September 13, 1992; member OSMA and AMA.

MILTON M. GOLDFARB, MD, Cincinnati; University of Cincinnati College of Medicine, 1953; age 68; died September 18, 1992; member OSMA and AMA.

PAUL W. HANAHAN, MD, Painesville; Case Western Reserve University School of Medicine, 1945; age 72; died September 10, 1992; member OSMA.

TUATHAL O'MAILLE, MD,

Marietta; National University of Ireland, Dublin, Ireland, 1956; age 60; died September 6, 1992; member OSMA and AMA.

WARREN L. RICHARDS, MD, Cincinnati; University of Cincinnati College of Medicine, 1947; age 69; died September 3, 1992; member OSMA.

RICHARD B. ROBROCK, MD, Duluth, MN; Case Western Reserve University School of Medicine, 1934; age 84; died September 10, 1992; member OSMA and AMA.

HOWARD H. SMEAD, MD, Aurora; University of Iowa College of Medicine, Iowa City, IA, 1937; age 78; died September 15, 1992; member OSMA and AMA.



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News for Members of the Ohio State Medical Association

HB 478 to impact Ohio physicians

Governor signs health-reform bill

Photo by Kristy VanKoughnet

In Brief: The health reform measures taken in HB 478 are only the tip of the iceberg ahead, but OSMA will continue to make health-care reform a top priority in 1993.

The passage of House Bill 478, the health-care reform bill that passed the Legislature late last year that, among other things, prohibited balance billing of Medicare patients and established two pilot projects that expand the nurses' scope of practice, should be considered a wake-up call.

"There is a feeling throughout the nation and state that health-care reform is needed," says John Verhoff, MD, chair of OSMA's Legislative Committee. "No matter how physicians may feel on this issue, there are people in society, in government and business who are looking for changes that will stem the cost of health care. This is a multifaceted issue,



Gov. George Voinovich signed HB 478 into law on January 14, while flanked by Rep. Wayne Jones (r) and Dave Heil, an aide to Sen Bob Ney.

and House Bill 478 is only the first step. We will see a number of legislative thrusts on the subject of health-care reform in the months to come."

Despite provisions that are

obviously onerous to physicians, Dr. Verhoff adds that the OSMA did the best job possible with the bill.

See **HB 478** page 2

OSHA cites 2nd MD

In Brief: The Ohio physician fined \$26,000 by OSHA negotiates a lesser amount. Meanwhile OSHA cites and fines another Ohio physician \$35,000.

The Ohio physician who was cited by the Occupational Safety and Health Administration for failure to comply with its blood-borne pathogen regulations, as reported last

month by *OHIO Medicine*, was able to negotiate, with the assistance of OSMA-recommended legal counsel, the \$26,000 fine to a significantly lesser amount. However, the Ohio State Medical Association's Department of Legal Services has learned that another Ohio physician has been cited by OSHA and fined \$35,000. Details on this case were unavailable at press time, but will be reported in next month's issue.

TAKE OSHA SERIOUSLY

This case emphasizes the importance of developing and following an exposure control plan tailored for your particular office. Your employees should be aware of the plan, its contents and location. Further, implementing the plan should be part of routine office procedure. ■

PIE letter of intent expires

At its regular January 30, 1993 meeting, the OSMA Council decided not to extend the letter of intent it signed with PIE Mutual Insurance Company (PIE) for the sale of OSMA's controlling shares of the Physicians Insurance Company of Ohio (PICO). The letter of intent, signed August 27, 1992, included a proposed minimum purchase price of \$750,000, a separate endorsement agreement and a standstill prohibiting OSMA from entertaining other offers.

The letter of intent also called for an independent appraisal of the value of OSMA's shares and

See **PICO** page 2

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■ **DEADLINE:** Resolutions for consideration by OSMA's '93 House of Delegates must be in by March 15. **10**

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Medical witness decision made.

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"We have a lot to be thankful for," he says. "At least we did not pass a bill like they have in Minnesota that assesses a provider tax. However, if we think we can sit back and say 'we've stemmed the tide' on health-care reform, we'll be sadly mistaken. Physicians need to become active in educating themselves and their patients on these issues. We need to educate those who pay the bill where the other problems lie. We need physicians to become involved in the grass-roots movement, and become more proactive."

OSMA MAY APPLY BRAKES

That doesn't mean of course, that the OSMA won't make it a top priority to keep reform legislation from becoming a runaway train. The association is presently considering two courses of action that may diffuse some of HB 478's impact.

One plan is the possibility of filing suit over the constitutionality of mandatory Medicare billing, the same action that other states have taken. However, all of these cases have lost in both the initial and appeals court process and, so far, the U.S. Supreme Court has refused to hear these cases. Since prospects in that direction look bleak, OSMA may take a second tact, and that is to develop a corrective bill that would introduce a few technical changes in HB 478 – but such changes could only be minor, and not the substantive changes most Ohio physicians would like

to see.

The fact is, this bill had bipartisan support throughout its long, and ultimately successful, run through the Statehouse, and Gov.

"If we think we can sit back and say 'we've stemmed the tide on health-care reform,' we'll be sadly mistaken."

George Voinovich supported the legislation since it fulfilled, for him, a campaign promise to "protect the elderly from excessive physician charges" by mandatory Medicare assignment.

WHAT'S IN STORE FOR '93

Health-care reform will return to the Ohio Legislature. "It's still a major concern, and there will

likely be a number of reform bills introduced – including UHIO (which would set up a Canadian-style health-care system in Ohio)," says John Van Doorn, director of OSMA's Department

of Legislation. However, he believes Ohio, like most legislatures, will take a wait-and-see attitude until the new administration and Congress have a chance to act.

"The Ohio Legislature now seems inclined to wait to see whether President Clinton and Congress will enact a health-care reform plan," says Van Doorn. But he's unsure how long state legislators are willing to wait if Congress delays federal reform measures.

Anyone wishing a summary of HB 478 should contact OSMA's Department of Legislation at 1-(800) 766-OSMA. ■

Are you overcharging your patients?

If you charge a patient more than \$500 over your usual, customary rate, you may be in violation of the new "overcharge" law, created by a provision of HB 478, the health-care reform bill that passed the Ohio Legislature last December.

In fact, a financial incentive is provided patients who identify such "overcharges" on a billing statement and notify their third-party payor. In such cases, a "reward," equal to 15% of the amount overcharged, must be paid to the patient by the provider or facility that overcharged.

"The OSMA pushed the Legislature to delete this language from HB 478. The OSMA opposes it in principle and because

it's so vague," says John Van Doorn, director of OSMA's Department of Legislation. Still unclear in the law's language are:

- whose usual and customary fees will be used to determine an "overcharge"?
- how will a physician or patient know what usual, customary fees are?
- who will judge what is an "overcharge"?

The Department of Insurance has been given no rule-making or enforcement authority on this matter, so there is presently nowhere to turn for answers.

"We'll attempt to have the

section removed when and if the legislature passes a bill to correct the problems found in HB 478," says Van Doorn.

In the meantime, Deborah Bahnsen, JD, staff counsel to OSMA's Ombudsman Department, gives this advice to OSMA members:

"Physicians should maintain one fee schedule with the exception of physicians who choose not to participate in the Medicare program. Physicians must be careful to charge the same amount for a particular health-care service, or procedure to each third-party payor. Physicians may agree to accept a discounted fee from any third-party payor or individual, but discounts must be applied after the initial billing." ■

PICO...From page 1

approval by appropriate government entities.

During the ensuing months PIE permitted the OSMA to discuss possible alternative transactions with PICO with the goal of negotiating a settlement satisfactory to the three groups. As late as Wednesday, January 27, 1993, the OSMA believed that the two Ohio insurers might successfully negotiate a settlement. However, by Friday afternoon it became apparent that OSMA's efforts to assist in multiparty negotiations would be unsuccessful.

The decision by the OSMA Council to not extend the letter of intent permits PICO, PIE and

others to make offers for the OSMA's controlling shares in PICO. Further, the expiration of the letter of intent eliminates the basis of claims made in the lawsuits filed by PICO and its minority shareholders against the OSMA and PIE and should result in their dismissal.

One of the four lawsuits filed to stop the proposed sale has been dismissed, and the Ohio Department of Insurance recently ruled in favor of the sale. (See related story at right.)

The OSMA Council continues to believe that it is to the advantage of the OSMA membership for it to divest OSMA of its Class B PICO shares. ■

ODI gives PIE favorable ruling

PIE Mutual Insurance Company has won the first two rounds in the legal wrangling involving OSMA's proposed sale of its PICO stock to PIE. The Ohio Department of Insurance issued a ruling approving of PIE's proposal to purchase OSMA's controlling stock in PICO.

Previously, federal district court in Columbus dismissed PICO's claim that the proposed transaction violated antitrust regulations.

The ODI found that, should the sale go forward:

- PICO would continue to be able to satisfy the requirements for issuance of a license to write the line or lines of insurance for which it is presently licensed.
- The acquisition would not substantially lessen competition in medical malpractice insurance in the state, or tend to create a monopoly in Ohio.

It also found that none of PIE's disclosed plans were inimical to the interests of the policyholders of PICO or the public. ■

AMA plans reform strategies for 1993

In Brief: Whatever President Clinton has in mind for health-care reform for 1993, the AMA intends to provide its own input, including key principles from its Health Access America plan.

It's still too early to know in what form the new administration will deliver its health-care reform measures. Buzzwords such as managed care competition and federal health-care budget that were bandied about in campaigns and pre-inaugural interviews remain unfocused and undefined. Still, one fact has emerged crystal clear. President Bill Clinton means to control health-care costs, and the sentiment in Washington seems to be the sooner the better.

AMA STRATEGIES

While the American Medical Association says it agrees with many of Clinton's campaign proposals, it is wary of discussions on a national health-care budget, and will actively oppose a national budget. In the meantime, the AMA will:

- continue to advocate principles in its Health Access America plan.
- work to establish federation unity so there will be one voice on key reform measures.
- develop policy specifications on the managed competition debate.
- help physician members respond to managed competition.
- continue to seek relief from anti-trust laws to allow physician negotiation, and to pursue self-regulation.

Watch future issues of *OHIO Medicine* to keep abreast of what promises to be an intensely debated and highly volatile issue throughout 1993. ■

More tax on alcohol, tobacco in '93

The Ohio Legislature passed a tax package in late December that raised taxes on both alcohol and tobacco products, effective January 1.

The OSMA supported the raise

designed by the governor to balance the state budget by the end of the year.

Over the next two years, the tax package will raise an additional \$860 million. However, "While

we are pleased that cigarette and alcohol taxes were boosted," says John Van Doorn, director of OSMA's Department of Legislation, "the OSMA, like other health-care groups, is disappointed that these dollars were not dedicated to expanding access to health-care in Ohio." ■

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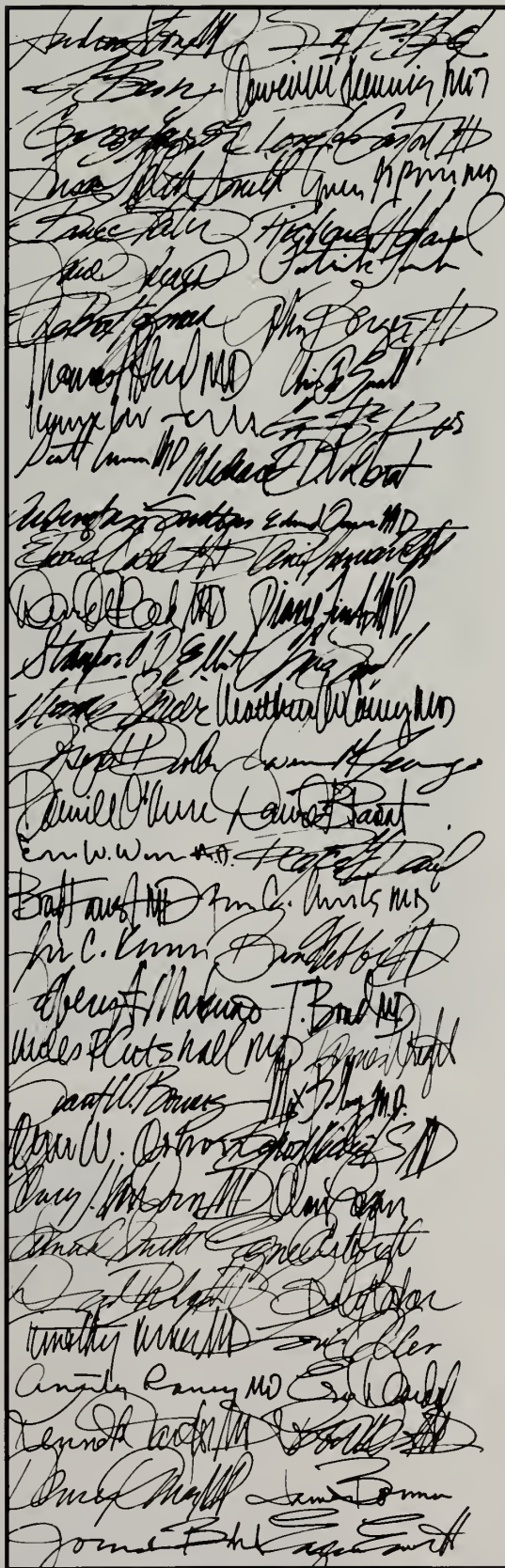
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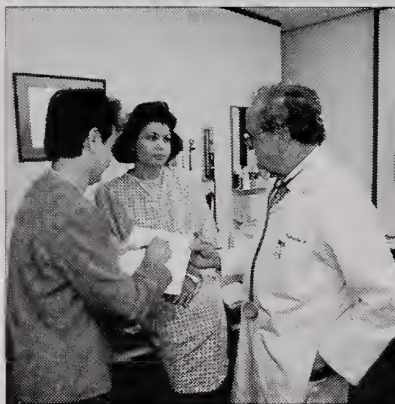
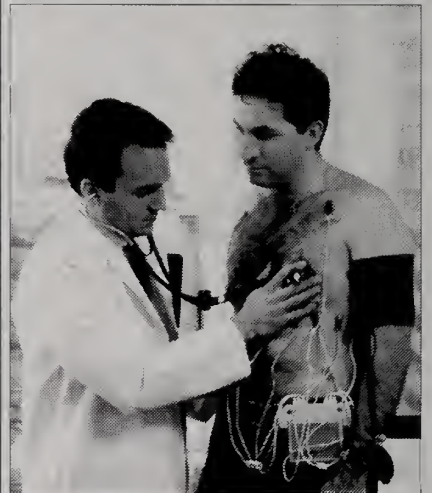
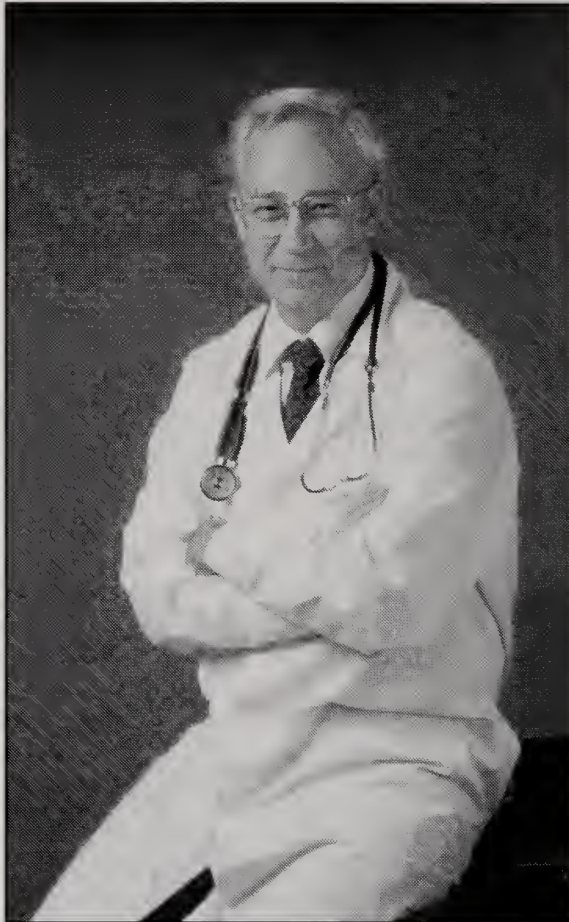
"After years of study, I honestly believed that I was ready to go into practice. I thought that knowledge and experience in medicine was all that I'd need to be a success out there. But, no one ever mentioned that I'd have to be an expert at insurance, law and collections...I'm a doctor, with a substantial amount of money and time invested in being the best that I can be. It didn't take long for me to realize that the time spent in managing my business was time taken away from the really important things in life; my patients, my family, and myself."

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PRESIDENT'S PERSPECTIVES

Health-care reform is here

Health-care reform was delivered in 1992 – as promised by both the governor and legislative leaders.

But House Bill 478, which passed as the year drew to a close, bore little resemblance to the health-care reform bills first introduced in January of 1992.

Although the OSMA is clearly not happy with some aspects of the final bill, it is important to remember that the association was very successful in removing the more burdensome portions of the original legislation.

When legislators first tackled health-care reform in January 1992, they were determined to solve this state's health-care cost and access problems by placing severe restrictions on physician reimbursement. The original legislation would have prohibited physicians from balance billing any patient; limited reimbursement from all payors to 110% of Medicare's reimbursement level; and established mandatory global hospital billing.

Through a year-long campaign involving a constant presence at the Statehouse and meetings with legislative leaders,

the association was able to convince legislators to remove all of those provisions from the bill and to shift the

focus of its reform efforts away from physician reimbursement.

In the cry of dismay some physicians have raised regarding the new law and its impact on physicians, I think we have lost sight of the fact that it was the health insurance industry, and rightly so, that bore the brunt of the legislator's efforts in HB 478.

As much as we may view it with distaste, compromise plays



Stanley J. Lucas, MD

an integral role in the legislative process. Legislators have been and will continue to be under constant and unrelenting pressure from their constituents to "do something" about health care. It was a given that health-care legislation would pass in 1992, the only question was: What form will that legislation take?

The OSMA worked long and hard to make certain that physician interests and concerns were represented at the Statehouse during the battle to make HB 478 law. We will continue to represent those interests during 1993.

As these legislators strive for solutions, compromise will be a part of that process – whether we like it or not. Despite this rather daunting fact, now is not the time to give up. We must continue our efforts to educate lawmakers about the health-care system and our rights and responsibilities, as physicians, under that system. If we don't do it, no one else will. ■

News & View

Bumps have changed

When I first started in practice, if a child fell and hit his head, getting a "goose egg," I'd tell the mother to take him home, lay him down on the couch and apply ice.

Nowadays, the mother calls 911 or rushes to a hospital for a minimum of \$70 for the call, another \$100 for an X-ray, and sometimes \$200 for a CAT scan. Then the mother is told to take the child home, lay him down on the couch and apply ice. Yes, I know about malpractice risks, but I still don't like it!

W.B. Rogers, MD
Cuyahoga Falls

Do you have a comment about something you've read or an opinion you'd like to share with your colleagues?

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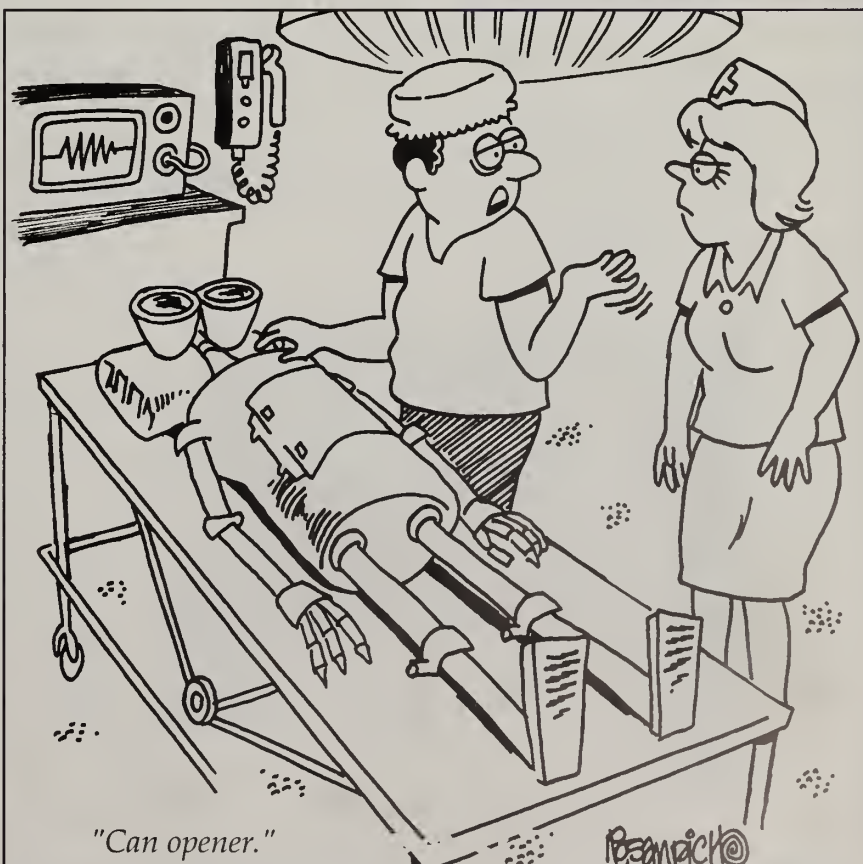
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AUXILIARY REPORT

Taking timely action

Time is one of those intriguing subjects of life. Whoosh! There goes a day...a week...a month! Yet there are other segments of time that pass with the speed of a glacier.

How real this is for me. Having passed the midpoint of my year as auxiliary president, I am now experiencing the "whoosh" problem as the clock is ticking to the conclusion of my term of office.

All auxiliaries who are in leadership positions are dealing with similar feelings of the time crunch. Membership challenges are facing us all. Our mutual goal is to give everyone an opportunity to join our ranks. Our mutual challenge is to achieve Plus One – one member for the county, state and national, to ensure the federation strong numbers.

We could work full time on fund raising for AMA-ERF, the importance of which cannot be overstated. With spiraling costs and shrinking sources for funds, medical schools increasingly

depend on sources such as AMA-ERF to help support medical education.

Our days are frequently filled with thoughts about the changes in medicine, and consequently the legislative affairs issues surface. With the climate of health care "change" the top priority of every legislator, we have major communicating to do with those elected to represent us. If each Ohio auxiliary took the time to journey to Columbus on March 10 to participate in "Communicating at the Capitol," I feel confident that we would make a difference in making our voices heard. We would be taking timely action for medicine. ■



Sara Rich, President

LETTERS TO THE EDITOR

Changing the playing field

To the Editor:

I noted Dr. Robert Elliott's letter in the December issue of *OHIO Medicine*, commenting on the service of physicians in the Ohio General Assembly, and pointing out that his father, Dr. Floyd Elliott, served in that body from 1935-1938. This fact I confirm, and add the information that Dr. Floyd Elliott served as Third District Councilor of the Ohio State Medical Association from 1958-1964.

Having served as legislation representative for the Ohio State Grange in the 93rd and 94th General Assemblies (1939 and 1941), prior to entering military service, I noted that medicine was well-represented with effective lawmakers.

Dr. H.T. Phillips of Athens County was chair of the Senate Health Committee in both 93rd and 94th Assemblies. Serving with him in the 94th was Dr. George G. Hunter of Ironton, a member of the committee.

Over on the House side, Dr. E. (Errett) LeFever of Athens County was chair of the House Health Committee in the 94th, and also on the committee was Dr. F.R. Stewart of Ironton. Dr. LeFever was starting his 11th two-year term in the House, and served on the Health Committee during the entire period, many times as the chair.

These physicians were highly respected "citizen legislators," and were typical of the men and women who were elected to state and national legislative bodies because they had "made their mark" in the community by the manner in which they conducted their business or profession. They were sent to Columbus or Washington as trusted servants of all the members of the community.

What became of the concept of the physician legislator? In my opinion, it was World War II. A total of 3,120 OSMA members were called into service – nearly half of the total members in 1942. Most areas, primarily the rural ones, were in short supply, and community pressures called for staying home to care for patients rather than campaigning for election and then serving in the state or national capital.

After the war, of those who returned from overseas, many had found pleasant climates during training; many sought specialty training, while the general demand for the service of a physician increased, perhaps because the community recognized that there had been much added to the armamentarium during war years. So, community pressures would still be influenced by the relative shortage of physicians, and the tendency was to stay home and care for patients.

Coupled with this was the shift to the "one man, one vote" concept after the war; a concept that doomed the future of the "citizen legislator." Smaller counties lost their legislator, and were forced to vote for someone, usually unknown to them, on a district basis.

Legislators had to spend more to become elected; salaries were raised, and whereas before the war the Assembly was in session from January through perhaps July every other year, it now borders on a full-time job. A professional man would have a difficult time maintaining his practice under these circumstances.

In my opinion, the desire of the physician to serve as a lawmaker has not changed...the playing field has changed.

HART F. PAGE

OSMA Executive Director Emeritus and OSMA historian

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SECOND OPINION

Waste and abuse in Ohio's Workers' Comp

By Joseph A. Solomayer, MD

Medicine "made in the USA" is the world's best, but when it comes to occupational medicine, we don't even get a passing grade! Let me explain why. First, with few exceptions, we don't teach our medical students the art and science of occupational medicine. Second, the providers of medical care have not seen, smelled, heard, touched or tasted the flavor of the patient's working environment. Finally, the physicians who perform Workers' Comp duties do not, or maybe don't wish to, know that to make a diagnosis of an occupational disease, one needs evidence. This evidence may be derived from: animal experiments and in vitro studies; epidemiologic evidence;

studies of the working environment; clinical evidence; and biological monitoring of the worker. Of course, none of the above means much without the history of exposure, which would reveal a specific, or several specific, toxic substances, capable of causing injury to the worker.

Only when all the evidence is in and confirms the diagnosis can one accept the hypothesis that an occupational injury or disease exists. Without the evidence, such a diagnosis cannot and should not be made. While the causes of accidental injuries are relatively obvious and easy to diagnose, the etiology of an occupational disease (Ohio recognizes 27) is much more complex and obscure to define.

Shouldn't that mean that we

should make greater effort to find the cause(s) and delineate the extent of the impairment? The answer is obvious. But who is watching the chicken coop when the doctors and other Workers' Comp providers are the foxes in charge of the chicken coop?

Because of poor data that is often distorted by poorly trained physicians and medical examiners, the Workers' Comp system hearing officer is being asked to do the impossible and adjudicate cases justly and swiftly. But only a medical expert can decipher such a puzzle of multiple etiology and/or combined health effect.

Who is to blame? The legislators and administrators who accept such poor documentation. But most of all the medical profession, for without a doctor's

signature, the system's waste, fraud and abuse could not take place. I am pointing my finger at the 10%-20% of our colleagues who give the rest of the 80%-90% of us an undeservedly poor reputation – but remember, we are just as responsible for the evil we allow as for the evil we commit! ■



Dr. Solomayer

Joseph A. Solomayer, MD, Euclid, is a clinical professor of occupational medicine at NEOUCOM.

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County doctors, auxiliaries launch domestic violence programs

TOLEDO MADE 1992 "YEAR OF AWARENESS"

Toledo and Lucas County physicians and auxiliary members addressed the problem of family violence in a number of ways during 1992. Here are some of the activities they pursued to bring the problem of family violence to the attention of both physicians and the community:

January – Robert McAfee, MD, from the AMA, spoke to physicians on the issue of family violence.

March – The auxiliary gathered telephone numbers for a hot line card, which they had printed and distributed to area hospitals, medical centers and clinics. Physicians were provided with these cards to hand out to patients they suspected may have been abused.

May – *Toledo Medicine* published an article "How Toledo Physicians Can Help Battered Women."

July/August – The auxiliary launched a public information campaign (jointly funded by the academy and auxiliary) that included a 30-second information commercial on family violence and how to get help.

December – Auxiliary members assembled fruit and vegetable baskets and prepared a Christmas brunch, served to women and children staying at the shelter. Teddy bears were

given to the children.

Ideas are now being considered for 1993 on new ways to promote further education in the community on domestic violence, and on ways to support victims.

– Rosemary Yanki, Auxiliary to the Academy of Medicine of Toledo and Lucas County

COLUMBUS AUXILIARY HELPS SPONSOR SEMINAR

On Feb. 10, members of the Auxiliary to the Academy of Medicine of Franklin County will sponsor a joint meeting with the academy, featuring a panel of experts who will share their experiences with family violence. The panel will encourage physicians to become familiar with domestic services in Columbus, and answer questions.

CINCINNATI ACADEMY: HOW TO LEAVE ABUSIVE PARTNER

The Cincinnati Academy of Medicine will hold "Women & Divorce: A Workshop," on February 13, in which such topics as how to leave an abusive partner, what to expect from the courts and how to cope with a new social status will be discussed. Among the featured speakers at the workshop are Paula Biren, MD, psychiatrist and Jean Siebenaler, MD, family physician.

Anyone who would like more information about the workshop should contact the Academy of Medicine at 320 Broadway, Cincinnati, OH 45202. ■

OSMA saves members \$2.5 million

OSMA's Workers' Compensation Group Rating Program will save 3,990 OSMA members a combined \$2.5 million in their annual Workers' Compensation premiums in 1993-94 – the second year of this valuable OSMA membership service.

This represents a sizable im-

provement over the number of OSMA members served in the first year of the program, when more than 2,800 OSMA physicians saved \$1.5 million in Workers' Compensation premiums.

The application process for the third year of the program begins next month. ■

CALENDAR

The OSMA has planned the following practice management workshops for 1993. Watch for more information on these workshops in future issues of *OHIO Medicine*.

Two Half-Day Workshops

Reception and Patient Flow Techniques – Designed to help anyone who may be involved with telephones and medical scheduling in a medical practice.

Better Collections, Billing and Insurance Techniques – Designed to improve the practice's results in dealing with the financial aspects of the medical office.

- Feb. 9 Concourse, Columbus
- Feb. 10 Holiday Inn – 1-675 – Fairborn
- Feb. 11 Quality Hotel, Cincinnati
- Feb. 23 Dana Center/Hilton, Toledo
- Feb. 24 Sheraton, City Center, Cleveland
- Feb. 25 Parke Hotel, Canton

One-Day Workshop

Managed Care – You will learn the key strategies to profitably negotiate contracts and how to organize your practice to fulfill the contracts efficiently. This workshop will also give you a better understanding of the various delivery systems and payment mechanisms.

- Mar. 2 Marriott, Cincinnati
- Mar. 3 Holiday Inn, I-675, Fairborn
- Mar. 4 Concourse, Columbus
- Mar. 16 Dana Center/Hilton, Toledo
- Mar. 17 Sheraton, City Center, Cleveland
- Mar. 18 Parke Hotel, Canton

Medical Office Management Institute (MOMI)

These workshops have been designed for medical office managers, supervisors and key employees. Some offices have used these workshops to upgrade the skills of established personnel as well as for indoctrination of new employees. The following five-day workshops can be taken in any combination:

- effective personnel management techniques;
- improving your managerial effectiveness;
- patient flow management;
- financial management;
- improving your third-party reimbursement and coding

June 28-July 2, Cleveland Stouffer Tower City Plaza, Cleveland
August 2-6, Cincinnati Kings Island Inn, Kings Island, Ohio

How to Run a More Profitable Practice

This one-day workshop is designed to show you the steps to a smarter, leaner and more profitable practice. Learn where your trouble spots are and how to bring them under control.

- Sept. 28 Marriott Airport, Cleveland
- Sept. 29 Concourse Hotel, Columbus
- Sept. 30 Marriott, Cincinnati

Colleagues

Oscar W. Clarke, MD, Gallipolis, was named "Distinguished Internist of 1992" by the American Society of Internal Medicine. Dr. Clarke, chair of the American Medical Association's Council on Ethical and Judicial Affairs and chair of the Ohio Medical Education and Research Foundation, is a past president of the OSMA and the Gallia County Medical Society.



Dr. Clarke

Antoinette P. Eaton, MD, Columbus, was inducted in the Ohio Women's Hall of Fame. Dr. Eaton, a pediatrician, is director of governmental affairs at Children's Hospital. She was the first female president of the American Academy of Pediatrics.



Dr. Eaton

Edward J. Fisher, MD, Cincinnati, was appointed medical director of the Adolescent Psychiatric Treatment Unit at The Jewish Hospital.

Steven Gabbe, MD, Columbus, was named assistant secretary of the American Gynecological and Obstetrical Society. Dr. Gabbe is professor and chair of the Department of Obstetrics and Gynecology at The Ohio State University Hospitals.



Dr. Gabbe

Rajesh Gaglani, MD, Columbus, was appointed by Gov. Voinovich to the Ohio Public Health Council. Dr. Gaglani is a partner and staff cardiologist in the Columbus Cardiology Clinic.

Ray W. Gifford, Jr., MD, Cleveland, received the American Heart Association's Bristol-Myers Squibb Lifetime Achievement Award in Hypertension. Dr. Gifford is vice-chairman of the Division of Medicine at Cleve-

land Clinic Foundation.

James E. Lewis, MD, Akron, was named director of Medical Education at Akron General Medical Center. He has been chief of Plastic and Reconstructive Surgery Service for 22 years, and is also director of the Joint Plastic

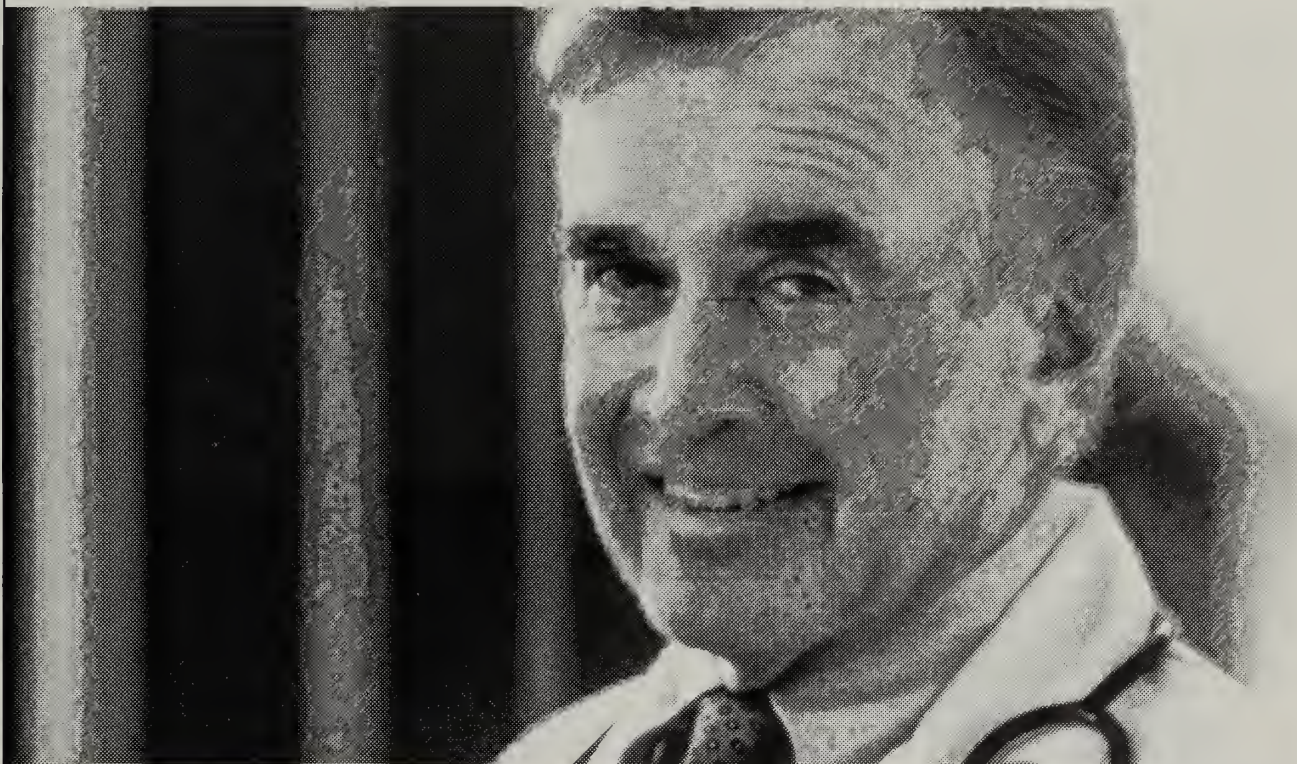
Surgery Residency Program in the city of Akron.

Richard D. Ruppert, MD, Toledo, was installed as president of the American Society of Internal Medicine. He is president of the Medical College of Ohio, a past president of the Ohio Society of

Internal Medicine, and a PICO trustee.

Donald M. Thaler, MD, Gallipolis, and his wife, Jan, were chosen Gallia County Persons of the Year. He is an orthopedic surgeon at Holzer Medical Center. ■

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OSMA resolution deadline nears

OSMA members who are considering filing a resolution for consideration at this year's OSMA House of Delegates have a few more weeks to put their thoughts down on paper.

Resolutions to be presented at the 1993 House of Delegates must be received by the OSMA executive director by midnight March 15 in order to qualify for consideration at the meeting. The Stouffer Tower City Plaza Hotel in Cleveland will be the site for the May 14-16 meeting.

If your resolution requires an expenditure of funds by the OSMA, attach a fiscal note estimating the expenditure.

After the resolution is filed, Brent Mulgrew, OSMA executive director, will prepare and transmit a copy to each member of the House of Delegates.

EMERGENCY RESOLUTIONS

In the past, some members who have missed the resolution deadline have attempted to have their resolution submitted as an emergency resolution. It is important for members to keep in mind that

an emergency resolution is justified only when events giving rise to the resolution occur after the filing deadline for resolutions.

A copy of the late resolution must be received by the Emergency Resolution Committee no less than 12 hours prior to the opening session of the House of Delegates.

If a majority of the Special Committee on Emergency Resolutions vote favorably to waive the filing and transmittal requirement, the resolution may be presented to the House of Delegates at the opening session. If, however, the committee votes unfavorably, the resolution will not be heard unless the House overrides the committee's decision.

For a copy of guidelines for submitting resolutions to the OSMA House of Delegates, contact your county medical society.

Send resolutions to: Brent Mulgrew, Executive Director, Ohio State Medical Association, 1500 Lake Shore Dr., Columbus, OH 43204-3824. ■



Health Care's Future

John A. Devany, MD, (left) past president of OSMA, and David J. Randall, deputy director of the Ohio Department of Insurance, sat on a panel to discuss the "Future of Health Care in America." The workshop, held in Columbus, was sponsored by the Health Care Quality Alliance.

OSMA-HMSS meeting to feature national, state legislative issues

Several timely issues are on the agenda for the annual OSMA Hospital Medical Staff Section meeting scheduled for May 14 from 9 a.m. to 1 p.m. at the

Stouffer Tower City Plaza Hotel in Cleveland.

HEALTH REFORM ADDRESSED

John Crosby, senior vice president of Health Policy Development for the AMA, will elaborate on the issue of federal health-care reform and national legislation.

John Van Doorn, director of the OSMA Department of Legislation, will address the much-publicized state health-care reforms. The latest on PRO practice parameters will be presented, as well as a discussion of the key concepts of the American Hospital Association's reform strategy for health-care delivery.

Lance A. Talmage, MD, Toledo, chair of the OSMA-HMSS, will speak on physician negotiation as it relates to medicine's role in health-care policy. A panel discussion will follow.

Prior to the educational session, members will meet to elect officers and consider resolutions. This meeting is being held in conjunction with the OSMA Annual Meeting. ■



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Committee briefs

IMG Task Force...The International Medical Graduates task force has been looking at the new licensure legislation that becomes effective in April and the Solarz-Kennedy bill, which sets up a panel to consider state-by-state licensure requirements for IMGs. The panel will be asked to identify discrimination in the licensure process... In its October 1992 issue *OHIO Medicine* ran an advertisement that the IMG task force found to be discriminatory. As a result all ads in *OHIO Medicine* are now screened for any sign of discrimination.

Physicians' Assistants...OSMA physician members of the OSMA-ONA-OOA Liaison Committee reviewed several legislative proposals being considered by the Ohio Association of Physicians' Assistants (OAPA). The proposals are: to clarify the PA's authority to transmit orders from a physician to nurses and other health-care personnel; permit institutional hiring of PAs; provide PAs with limited prescriptive privileges; and change the PA's status from registered to licensed. A meeting of OSMA representatives on the committee and representatives of OAPA was held in late 1992. The OAPA promised to consider language that would address OSMA concerns about definition of supervision, physician-delegated prescriptive privileges based on a protocol format, and the relationships between PAs and nurses.

Membership activities...The OSMA Committee on Membership joined the Academy of Medicine of Columbus and Franklin County in a two-year pilot program that would offer a 50% dues discount to physicians in Franklin County who are employed in the practice of medicine less than 20 hours per week. The committee will also form a Group Practice Advisory Committee to advise the association's group practice membership initiative.

Auxiliary news...OSMA Auxiliary President Sara Rich

asked for and received Council approval for a change in the OSMA constitution and bylaws to allow the president of the OSMA-A to have a vote on the OSMA Council. Council will sponsor a resolution at the 1993 OSMA Annual Meeting proposing this change. It was agreed that this proposed change would

not give the auxiliary president a vote at the OSMA House of Delegates.

Committee on Education...A task force was appointed to develop focused educational programs for physicians in Ohio. Sitting on this task force will be members of the OSMA Commit-

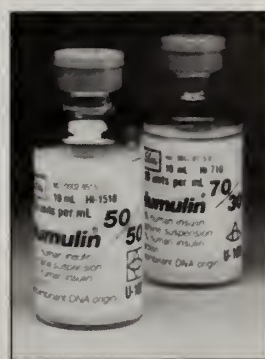
tee on Education, Ohio State Medical Board, the Ohio Hospital Association and Peer Review Systems, Inc... A fee of \$100 per credit hour for courses jointly sponsored with organizations not affiliated with OSMA was approved.



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Members respond to tabloid survey

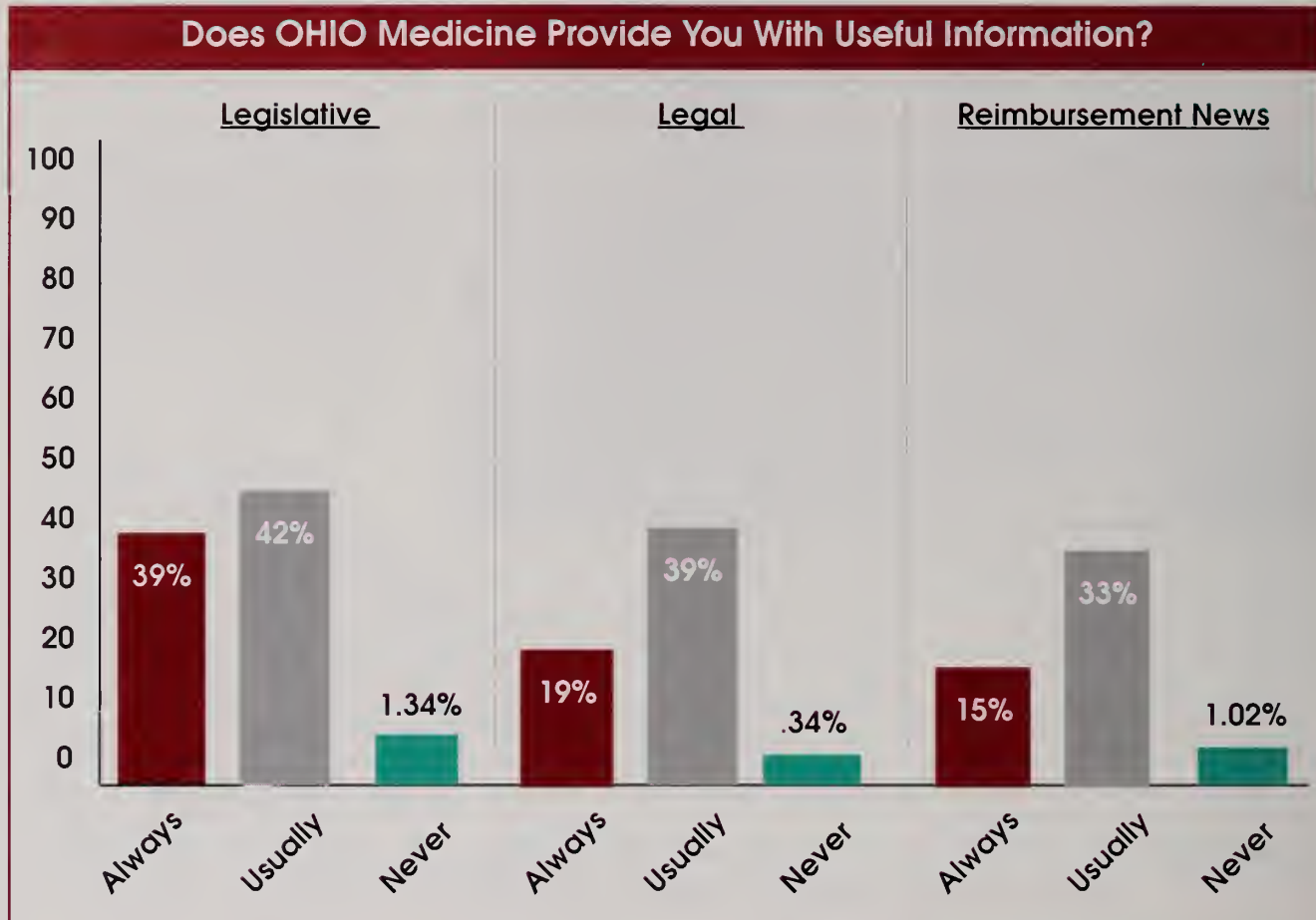
In Brief: OHIO Medicine celebrated its first birthday by asking members to evaluate the effectiveness of the publication. By and large, it received good marks.

OHIO Medicine readers were recently asked to play editor in a survey conducted on the new publication. Most of the 913 respondents gave high marks to OHIO Medicine for its effectiveness in communicating information to its readers.

LEGISLATION RANKS #1

More than half of the readers always read at least the front page of the new publication with the Legislative section ranking highest, followed closely by Legal and Third-Party Update. The Commentary section, including Letters to the Editor, the president's message and Second Opinion written by fellow physicians, also provided useful information to readers.

Finding time to read the publication is still the biggest complaint most physicians had. One



reader suggested a "30-hour day with an eight-day week" as a possible solution.

WHAT READERS WANT TO SEE

When asked what topics readers would like to see included in future issues of OHIO Medicine a number of respondents indicated they would like names and addresses of legislators included in articles as well as a scorecard on how these legislators voted on health-care issues.

The actions of the Ohio State Medical Board, Medicare updates, reimbursement issues and malpractice information are also of concern to readers.

One reader went so far as to say that "OHIO Medicine needs to take a firm stand against continued government bureaucracy and encroachment on medicine." Another wanted the publication to discuss more "controversial issues."

DEBATE OVER TABLOID'S SIZE

The size of the tabloid continues to be debated. Many pointed out that a smaller size would be easier to handle, yet when readers ranked the overall appeal and

layout/design most indicated they liked the present format very much. Some suggested keeping stories shorter in length to avoid jumping material to another page, which would allow articles to be copied and filed more easily.

The new format was specifically designed to bring readers more up-to-date information in a form that involves minimal reading time – and this policy is followed as often as possible.

The OHIO Medicine staff will take all of these suggestions into consideration and will try to incorporate these new ideas into upcoming issues.

Auxilians to meet with legislators

"Communicating at the Capitol" has replaced the Ohio State Medical Association's auxiliaries' annual "Day at the Legislature." But while the name has changed, the objective remains the same: Meet your local legislators and discuss issues and legislation that affect health care.

The meeting will be held March 10 from 8:30 a.m.-4:30 p.m. at the Riffe Center in Columbus, and

will feature several speakers, including fellow auxiliary Rep. Rose Vesper. Auxilians will also have time to keep individual appointments they have previously made with their legislators, and the day will end with an hour-long reception at the Capitol Club.

For information contact Carol Wenger at (800) 766-OSMA.

How Often Do You Read OHIO Medicine?

| | |
|------------------|--------|
| Always | 39.73% |
| Usually | 33.52% |
| Often | 12.10% |
| Sometimes | 12.87% |
| Never | 1.55% |
| Don't Know | 0.22% |

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Ohio suit tests Disability Act

In Brief: If the suit goes forward, Ohio physicians may have a better definition of how they must respond under the Americans With Disabilities Act to patients with AIDS.

What may be the first Ohio lawsuit brought under the Americans With Disabilities Act was recently filed in federal court by the ACLU on behalf of Fred Charon, a person with AIDS who sought treatment at Memorial Hospital in Fremont.

Charon, a resident of Maine who was traveling through

A Toledo area hospital denied treatment to an AIDS patient.

northwest Ohio, apparently experienced a reaction to medication he had begun taking for a non-AIDS-related infection. Charon sought emergency treatment at the hospital after contacting his physician in Maine.

The lawsuit alleges that an emergency department physician initially indicated that Charon would be admitted to the hospital. Shortly thereafter, the same physician informed Charon he would not be admitted because the back-up physician did not want to admit him. The emergency physician then arranged for Charon to be transferred to the Medical College of Ohio.

ILLEGAL DISCRIMINATION

As a result of these events, the lawsuit alleges that the back-up physician and the hospital illegally discriminated against Charon in violation of the Americans With Disabilities Act and Federal Rehabilitation Act. The lawsuit further alleges that the back-up physician and hospital inappropriately transferred Charon in violation of the Emer-

gency Medical Treatment and Active Labor Act. Tort claims of intentional and negligent infliction of emotional and physical distress have also been raised.

Under the ADA, places of public accommodation must make their facilities and services ac-

cessible to persons with disabilities. This requirement may be excused if a person poses a "direct threat" to the health and safety of others that cannot be eliminated by modifying practices or procedures, or providing the service would impose an "un-

due burden" on the facility. If the lawsuit goes forward, it will help define how physicians and hospitals must respond under the ADA to patients with HIV, AIDS or other disabilities who seek treatment at health-care institutions. ■

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Cleveland doctors dispute "employee" status

In Brief: Hospital-based physicians at Cleveland's MetroHealth/St. Luke file suit to keep from being "hired."

About 40 Cleveland physicians are bucking what appears to be a growing national trend – physicians as hospital employees.

At odds in the dispute, which has been going on for about a year, are doctors and administrators at MetroHealth St. Luke's Medical Center. The hospital would like to hire physicians individually after their current contracts expire.

Radiologists and emergency physicians at the hospital recently filed suit to stop the hospital from hiring new physicians after their contract ended on Dec. 31. Meanwhile, a group of pathologists and anesthesiologists at the facility, believing the same thing will happen to them when their contracts end in July and September, also have retained legal counsel.

WHAT'S AT STAKE

For the physicians, at stake is the welfare of the patient, which

they contend will suffer because the hospital, as a corporation, is concerned with saving money, which will affect patient care.

The physicians also contend that the hospital would be violating a 30-year-old ruling by the Ohio attorney general that corporations cannot hire physicians. (The hospital questions the validity of the ruling, noting that Ohio is one of only five states with such a legal doctrine.) House Bill 478, the health-care reform bill that passed the Legislature late last year, at one time carried a provision that would have repealed the prohibition against the corporate practice of medicine. This would have permitted hospitals to employ physicians rather than contract their services individually. Thanks, in large part, to OSMA's legislative efforts, this provision was dropped from the bill last June.

For the hospital, employing physicians would make it more attractive to managed care programs, employers and other insurers, because fees wouldn't have to be negotiated separately between hospital and physicians.

Benefits would be seen when dealing with insurance and other companies for the same reason.

The doctors' suit, however, was put on hold until late last month by Cuyahoga County Common Pleas Judge Patricia Cleary, in the hopes the two sides can come to an agreement – something attorneys for both sides say is doubtful. *OHIO Medicine* will keep you posted on the outcome. ■

Should Doctors Be Employees?

Physicians contend:

- Welfare of patients at stake.
- 30-year ruling by Ohio attorney general says corporations can't hire physicians.

Hospital contends:

- Validity of ruling is questionable
- Negotiating separate physician fees makes hospital less attractive to managed care programs, employers, insurers.

Update

PICO/PIE/OSMA discuss settlement

The PICO/PIE/OSMA triangle continues to develop, as now both PICO and PIE discuss settling their disagreements. In the past, *OHIO Medicine* reported that PICO had filed several lawsuits against the OSMA in an attempt to stop OSMA's sale of its Class B PICO shares to PIE. Now, "Both PICO and PIE have made settlement offers," says Katrina English, director of the Department of Legal Services. "The litigation has temporarily been halted, but if we can't come to a settlement that will please all parties, then the litigation will continue." Meanwhile, all three parties are awaiting the report from the Department of Insurance's hearing examiner, who was to examine the legalities of the proposed sale.

UR company held not liable for malpractice

A federal appeals court in Houston held that a utilization review company cannot be held liable for medical malpractice based on its decision to deny benefits. In *Corcoran v. United Health Care*, prenatal hospitalization for a patient whose baby later died was refused after United, a review company, refused to authorize benefits. UR decisions are made by insurers either in-house or by independent companies, sometimes without input from the patient's physician. The risk of reviewing UR decisions rests on the doctors who may remain liable for bad outcomes even when a UR decision conflicts with the doctor's recommendations. Patients, upon learning that insurers won't be liable, may decide to go after their doctor instead. The Corcoran case may result in physicians bearing the burden of appealing UR decisions that conflict with their recommendations.

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Supreme Court: Expert witnesses don't have to be doctors

The Ohio Supreme Court recently ruled that expert medical witnesses do not have to be physicians. The court's ruling overturned an earlier Court of Appeals decision. In *Shilling v. Mobile Analytical*, John Shilling sued Mobile Analytical Services, Inc. (MASI) alleging negligence in testing his family's well water, which he suspected was contaminated and the cause of his multiple sclerosis. After two negative tests, the Shillings had a second company test the water, which showed gasoline contamination.

"A witness is qualified by knowledge, skill or experience."

MASI protested, however, that an expert witness had not shown that drinking the water caused the family injury.

The Shillings then introduced testimony by Raymond Singer, PhD, a neurotoxicologist/psychologist, who concluded that the Shilling family had, in fact, suffered varying degrees of brain damage as a result of ingesting the contaminated water.

TRIAL COURT WANTS MD

The trial court refused to consider Dr. Singer's affidavit, holding that, because any opinion on the cause of physical problems is a medical diagnosis, an expert who renders such an opinion must be a medical doctor. The Court of Appeals affirmed the trial court's decision, but the Ohio Supreme Court found that Dr. Singer was qualified to testify that the ingestion of gasoline causes injury to the brain and nervous system, namely because of his skill, knowledge, experience and training in neurotoxicology.

The Supreme Court also noted that "medical witness" need not solely refer to physicians, as they

often rely on lab results performed by non-physicians to come to medical conclusions.

All that is required is that the witness be qualified by "knowl-

edge, skill, experience or education" to testify on a particular subject. Dr. Singer was qualified to testify that the ingestion of gasoline caused injury to the

brain and nervous system. Even though additional testimony may be required to establish a connection between brain damage and the plaintiff's symptoms, conclusions that do fall within Singer's expertise should not be disallowed, the court ruled. ■

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AMA reports available to members

OSMA members interested in obtaining reports from the American Medical Association's meeting in Nashville in December may do so by contacting: Shar Wackman, at the OSMA, 1-(800) 766-OSMA. Please request the reports by number.

1. Medicare Volume Performance Standard
2. Report of the National Commission on Children
3. Air Bags and Preventing Crash Injuries
4. Tobacco Control Update
5. RVS Updating: Status Report and Future Plans
6. The Medicare "Hassle Factor" Semiannual Report
7. Medicare Physician Payment Reform: The First Year
8. Prioritization of Health-Care Services
9. Americans With Disabilities Act Update
10. Global Budgeting in Health System Reform Proposals
11. Information on Physician Fees
12. OSHA Bloodborne Pathogen Regulations
13. 1993 Medicare Payment Schedule
14. Caring for the Poor
15. Prenatal Genetic Screening
16. AMA Initiatives Regarding the Environment
17. Effects of National Health-Care Reform on Medical Education
18. Guidelines for Disclosure of Medical Records Information to Payors
19. Autologous Blood Transfusion
20. Health-Care Access for the Inner-City Poor



County Elects Officers

The leaders of the newly reactivated Highland County Medical Society are, from left: Ron A. Zile, MD, Hillsboro, co-president; Jeannette M. Morgan, MD, Greenfield, alternate delegate; and Thomas R. Wright, DO, Greenfield, co-president. These are the first officers and delegates elected in Highland County since 1978.

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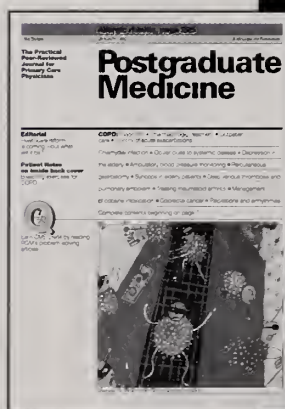
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- "The Body Clock: Diagnosis & Treatment of Shift Work"

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CLIA extends grace period to March 1

Physicians now have until March 1 to obtain their Clinical Laboratory Improvement Amendments (CLIA) registration number without having claims for laboratory services denied. The CLIA grace period was extended again because the government is not ready to implement the program.

After March 1, Medicare carriers will notify physicians if federal records do not indicate a CLIA number is on file. Physicians then have three options: request the necessary forms to become a CLIA-registered lab; notify the carrier that its records are in error and provide the carrier with correct CLIA registration number; or stop performing laboratory tests.

Payments, however, will not be denied until proper notification is given to the physician.

HCFA FORMS AVAILABLE

Physicians who have either obtained or are in the process of obtaining a CLIA registration number should receive HCFA forms 114 and 116. Physicians who have not previously applied for a CLIA registration number may use these forms to apply for the number. Form 116, section VI, requires physicians to choose between private and federal accreditation. If the physician chooses

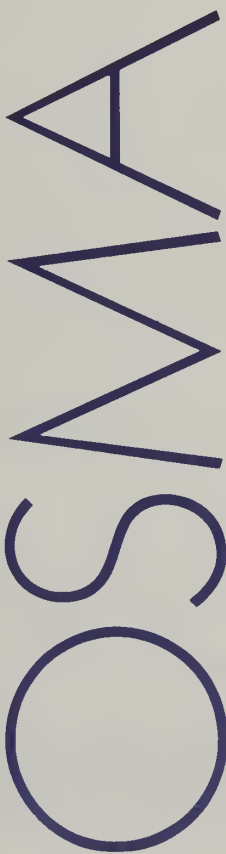
federal, he or she will automatically receive the federal inspection materials. If a physician chooses private, that particular source must be contacted. (Look for more information on private accreditation in next month's *OHIO Medicine*.)

If your office includes a lab that does tests other than waived tests, prepare to have your lab inspected sometime within the next two years. In 1993, more than 100,000 physicians will be surveyed to determine whether their office labs meet CLIA re-

quirements.

Unless a problem is suspected, or a complaint has been received, physicians will receive a three-day written notice before a CLIA inspector shows up at the door.

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If the carrier doesn't have your CLIA number on file, here are your options:

- Contact HCFA or OSMA to request necessary forms to become a CLIA-registered lab.
- Notify carrier that their records are in error and provide the carrier with the correct CLIA registration number.
- Stop performing laboratory tests.

Physicians: Balance billing law in effect

House Bill 478, which passed the Ohio General Assembly late in 1992, prohibits physicians from balance billing their Medicare patients who live at or below 600% of the federal poverty level (approximately \$40,000/yr.). This law is effective now. This new law does not affect billing for Medicare coinsurance, deductibles or for services not covered by Medicare.

Medicare patients may report physicians they suspect of violating this prohibition on Medicare balance billing to the Ohio Department of Health (ODH). Physicians who violate this law may be publicly reprimanded and forced to repay the patient, plus pay interest and a \$500 fine. Second and subsequent violations would result in fines of \$2,000 per incident, plus repayment and interest. Physicians found to be in violation may appeal to ODH, but could be assessed hearing costs of up to \$25,000, should they lose the appeal.

Keep in mind that physicians who fall into the following two categories are not affected by this new ban on Medicare balance billing:

1. Physicians who participate in the Medicare program. Participating physicians, through a contractual agreement with Medicare, may not collect from Medicare patients more than the coinsurance and any unmet deductible.
2. Physicians who do not participate in Medicare, but also do not collect from Medicare patients more than the nonpar fee schedule amount. Physicians who do not balance bill up to the Medicare Limiting Charge do not need to certify their Medicare patients' income levels.

Physicians who do not participate in Medicare and do plan to bill their higher income Medicare patients for the difference between Medicare's Allowed amount and the Medicare

Limiting Charge should verify patient income in some manner.

As a member service, OSMA has developed the income verification letter printed below. This form has been reviewed by legislative leaders as well as the ODH. To the OSMA's knowledge,

no other group will be developing a form.

The OSMA recommends that physicians who plan to collect from their Medicare patients up to the Medicare Limiting Charge photocopy a supply of the following form and have all of their Medicare patients complete the form as part of their next office or hospital visit. This letter should

be kept in the patient's file. Then, in the event a question should be raised regarding a balance billing, the physician will have a record of the patient's income level.

If you have any questions about this form or the new prohibition, please contact the OSMA Ombudsman Department at (800) 766-OSMA.■

Income Verification Letter

Should be clipped and photocopied by physicians who need to verify Medicare patients' income.

Dear Medicare Patient:

In compliance with a new Ohio law, it is necessary for you, as a Medicare patient, to disclose to this office whether or not your annual income is above or below approximately \$40,000 a year. Under this new law, Medicare patients with incomes below this level must be billed differently.

I apologize for this invasion of your privacy and assure you that this information will be strictly confidential.

You do not need to disclose your exact income; you only need to indicate whether your income is above or below the set amount. By income, we mean your earnings, plus payments from pensions and other retirement plans, payments from Social Security and interest on savings, etc. Keep in mind that this would be your gross income; that is, your income before you deduct expenses or taxes. If you don't know this figure, you can get it from your income tax form from last year.

Please read the following statements and initial the statement that applies to you. Then sign and date this form. This form will be kept in your file in this office.

- _____ My annual income is **more** than \$40,860 a year as an individual or \$55,140 a year as a family of two. I realize that this means that I agree to continue with the financial arrangements as a Medicare patient as they existed prior to the new law. I understand that I will continue to be responsible for payment of any balance on my bill that is not covered by Medicare or other insurance, including noncovered services.
- _____ My annual income is **below** \$40,860 a year as an individual or \$55,140 a year as a family of two. I understand that this means that I will only be charged the Medicare Allowed Amount for services rendered by this office. I further understand that I will continue to be responsible for payment of services not covered by the Medicare program.

Date

Please print name

Please sign name

If you have questions or concerns about the new law, or if your income level changes, please talk with me or someone on my staff.

Q & A For Nonparticipating Physicians

Q. I have chosen not to participate in the Medicare program during the year of 1993. Under House Bill 478 provisions, what amount may I collect from my Medicare patients?

A. It depends upon your patient's annual income. If the patient's income is above \$40,860 per year, nonpar doctors may continue to collect from the patient up to the Medicare Limiting Charge. If, on the other hand, the patient's income is below \$40,860 per year, nonpar doctors may only collect up to the Medicare Nonpar Allowable. A review of the Medicare Locality Fee Schedule Report sent to all physicians by Medicare will provide both the Limiting Charge amount and the Nonpar Allowable amount.

Q. When did the provisions of HB 478 go into effect?

A. January 14, 1993, the day the governor signed it.

Q. How am I expected to know my Medicare patient's annual income?

A. It will be up to the physician to obtain this information from the patient. The OSMA has developed an Income Verification Form to assist physicians in obtaining this information. See the sample form on the facing page.

Q. Must I inquire about my Medicare patients' income?

A. Maybe. If you plan to collect up to the Medicare Limiting Charge from any Medicare patient, it will be necessary for you to determine the patient's

income. However, if you have decided to bill all of your Medicare patients no more than the Medicare Nonpar Allowable, it will not be necessary to verify income.

Q. What happens if a Medicare patient refuses to discuss personal income?

A. If you have no idea of the patient's personal financial situation, then the physician should collect no more than the Medicare Nonpar Allowable.

Q. My medical practice is in Ohio, but I treat many Medicare patients who reside in another state. Do the restrictions in HB 478 apply to these patients?

A. Yes. The law states that Ohio health-care providers (including physicians) who treat Medicare-enrolled patients must adhere to the balance billing limitations and since you practice in

Ohio, these limitations would apply.

Q. I have a practice in both Ohio and in Kentucky. If I see a patient who lives in Ohio in my Kentucky practice what are the implications of HB 478?

A. HB 478 applies to Ohio health-care providers who render services in Ohio. Physicians practicing in Kentucky are practicing under their Kentucky medical license and would not be subject to balance billing limitations.

Q. Are my patients still responsible for services that are noncovered by Medicare?

A. Yes. Services that are always noncovered by Medicare continue to be the patient's financial responsibility. Additionally, patients may also be responsible for payment of services that may not be reimbursed by

Medicare, for lack of medical necessity, so long as the physician has a signed Advance Notice Form on file from the patient who has agreed to be responsible for payment.

Q. If my patient's income is below \$40,860 and I choose to accept assignment on a claim, may I collect up to the Par Allowable?

A. No. Only physicians who have signed a Participating Agreement may collect up to the Par Allowable.

Q. Is it too late for me to participate in the Medicare program for 1993?

A. Yes. The deadline to participate with Medicare for 1993 ended December 31, 1992. Physicians who wish to participate in 1994 may sign an agreement with Medicare in December of 1993.

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Q & A For Participating Physicians

Q. As a participating physician, what amount can I charge for my professional services?

A. Participating physicians may charge their UCR fee to Medicare. In other words, whatever fee is billed non-Medicare patients. But, par physicians cannot collect any more than the Medicare allowable, which Medicare reimburses 80% directly to the physician, leaving 20% to be collected from supplemental coverage, or the patient. Any difference between the allowed amount and the physician's charge must be written off as uncollectible.

* The exception is psychiatry with additional reductions. This is addressed in a later question.

Q. To avoid write-off's, why shouldn't I just charge the Medicare allowable?

A. Physicians are advised to submit their usual and customary fees to all carriers, including Medicare if you participate. Besides, to have only one fee schedule for all patients may be easier administratively. (As a side note, if physicians were to bill Medicare no more than the Medicare allowable, it would appear that Medicare is approving for payment of 100% of the physician's fees.)

Q. Am I allowed to collect any money from the Medicare patient?

A. Yes. Physicians may collect from the Medicare patient 20% of the Medicare-approved amount and any portion of the unmet \$100 annual deductible, plus any fees for noncovered services.

Q. Must I collect the Medicare coinsurance and deductibles from my patient, or may I simply write it off?

A. Federal law requires physicians to make a reasonable effort to collect the coinsurance and deductible amounts from Medicare patients. Although there are a few circumstances under which the coinsurance and deductible may be waived (such as a particular patient's indigency) routine waivers of coinsurance and deductibles may constitute a violation of federal rules.

Q. How will I know how much Medicare is going to approve for payment?

A. In advance of payment from Medicare, physicians have the ability to know the allowed amount by reviewing the Medicare Locality Fee Schedule Report sent to all physicians by Medicare. Medicare will approve for payment the amount that appears in the column labeled Par Amount. Another way is to wait until the claim is processed by Medicare and review the Summary of Medicare Benefits that is sent to physicians along with the 80% payment.

Q. How will I know if the patient has met their \$100 annual deductible?

A. The most accurate method is to review the Medicare Summary of Benefits after the claim has been processed by Medicare.

Q. May I collect the 20% coinsurance from my patient at the time of services?

A. Yes. However, physicians should keep in mind that Medicare may not approve all charges submitted and in some cases, it may be necessary to make a refund to the patient.

Q. Is it all right if I don't collect any money from my patient at the time of visit, and simply bill Medicare directly?

A. Yes. And for many offices, this is the preferred method. Billing your patient after Medicare has processed the claim assures accuracy in posting to the account.

Q. May I collect the full Medicare Allowed amount from my patient at the time of visit, if I know that the patient has not met their annual deductible?

A. Physicians are discouraged from collecting more than the 20% coinsurance from the patient at the time of visit, simply because of the uncertainty of any unmet deductible amounts.

Q. If I collect the 20% coinsurance at the time of service, must I show the amount collected from my patient in block #29 of the HCFA-1500 claim form? I was told that this could cause problems when the claim is processed by Medicare.

A. Physicians who choose to show a patient payment on the HCFA-1500 claim form may do so, however problems can occur where a claim is filed for a non-covered service and a patient payment is shown in block #29 or when a payment is made on a previous balance.

Q. May I collect the entire fee from my patient at the time of the visit, then when Medicare sends me the 80%, make a refund to my patient?

A. No. This is a violation of the Medicare Participating Provider Agreement.

Q. Are coinsurance and deductible amounts applicable to laboratory services?

A. No. Laboratory services are reimbursed based on a statewide fee schedule, and coinsurance and deductibles do not apply. Medicare will reimburse the physician 100% of the fee schedule amount for covered services.

Q. Must I continue to submit separate claim forms for lab services when they are performed on the same day as other services?

A. No. Since par physicians accept assignment for all services, it is not necessary to submit separate forms. In the past it was only necessary to file a separate claim when some of the services (non-lab) were to be processed nonassigned and lab services were to be processed assigned.

Q. May I collect from patients any fees for services that are noncovered under the Medicare program?

A. Yes. Patients continue to be responsible for services that are never covered under the Medicare program. In addition, patients who have signed a Medicare Advance Notice Form

Q & A For Participating Physicians

continue to be responsible for any services denied under the medical necessity guidelines.

Q. Is there a different coinsurance amount for psychiatric services?

A. Yes. Medicare reimburses par psychiatrists at 62.5% of the allowable, reduced by 80%. Thus, the patient has a higher out-of-pocket expense for outpatient mental health services. The par psychiatrist may collect up to the par allowable, not the reduced allowable.

Q. Must I continue to have my patient sign an Advance Notice form for services that Medicare may not consider to be medically necessary?

A. Yes. Because there are many services that Medicare may determine it will not cover based on medical necessity. A signed Advance Notice Form ensures that the patient will be responsible for payment of these services in the event that Medicare denies coverage.

Q. Must I file a claim to Medicare for services that Medicare always considers to be non-covered?

A. No. In fact, Medicare advises that physicians should **not** file a claim for services that are never covered under the Medicare program.

Q. Must I file a claim form

to my patient's secondary carrier?

A. No. However, many physicians choose to file to the patient's secondary insurer simply to assist the patient.

Q. How do my patients know what services are never covered by Medicare?

A. The Social Security office provides a booklet to Medicare patients, entitled the Medicare Handbook. Included in the handbook is a list of services that are always noncovered by Medicare.

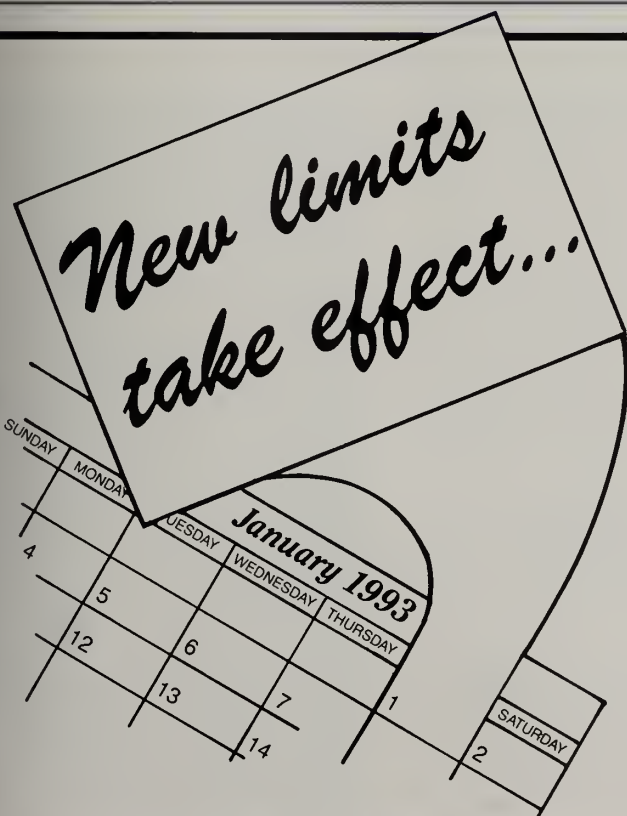
Q. Must I continue to disclose estimated charges, and the

patient's out-of-pocket expenses for elective surgeries of more than \$500?

A. No. Only nonparticipating physicians must disclose this information to patients in advance of rendering the service.

Q. Because I participate with Medicare, will my patient's secondary carrier honor assignment, and pay me directly for the 20% coinsurance on claims that are crossed over electronically from Medicare?

A. Probably not. Unless physicians have a participating contract with the secondary carrier, co-payments by the secondary carrier will likely go directly to the patient. ■



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Obituaries

LINCOLN C. DICKEY, MD, Shaker Heights; Case Western Reserve University School of Medicine, 1935; age 82; died October 5, 1992; member OSMA and AMA.

HARRY L. DUNCAN, MD, New Matamoras; Medical College/Virginia Commonwealth University School of Medicine, Richmond, VA, 1928; age 95; died September 24, 1992; member OSMA and AMA.

DONALD E. HUGHES, MD, Van Wert; Case Western Reserve University School of Medicine, 1945; age 71; died September 25, 1992; member OSMA and AMA.

ELMER L. JACKSON, MD, Shelby; Case Western Reserve University School of Medicine, 1933; age 87; died September 30, 1992; member OSMA and AMA.

WILLIAM KUBICEK, JR., MD, Cleveland; St. Louis University School of Medicine, St. Louis, MO, 1941; age 77; died September 16, 1992; member OSMA.

THEODORE L. LIGHT, MD, Dayton; University of Cincinnati College of Medicine, 1938; age 87; died October 17, 1992; member OSMA and AMA.

CARMELITO OLAES, SR., MD, Brunswick; University of Santo Tomas, Manila, Philippines, 1969; age 48; died September 14, 1992; member OSMA and AMA.

VIRGIL A. PLESSINGER, MD,

Cincinnati; University of Cincinnati College of Medicine, 1936; age 81; died October 25, 1992; member OSMA and AMA.

JOHN A. PRIOR, MD, Columbus; Ohio State University College of Medicine, 1938; age 79; died October 14, 1992; member OSMA.

FRANKLIN RODABAUGH, MD, Bluffton; Ohio State University College of Medicine, 1941; age 78; died September 20, 1992; member OSMA and AMA.

NELLIJA O. RUBENIS, MD, Columbus; Latvijas Universitate Medicinas Fakultate, Riga, Latvia, 1937; age 78; died March 1992; member OSMA and AMA.

WILLIAM L. SANTEN, MD, Cincinnati; St. Louis University School of Medicine, St. Louis, MO, 1954; age 63; died October 13, 1992; member OSMA.

DONNA SIMPSON-RAND, MD, Georgetown; University of Cincinnati College of Medicine, 1985; age 40; died October 6, 1992; member OSMA and AMA.

PAUL L. SUHAY, MD, Brecksville; Loyola University Stritch School of Medicine, Maywood, IL, 1936; age 84; died October 1, 1992; member OSMA and AMA.

Correction

OHIO Medicine regrets that in its December Obituary section Charles J. Cooley, MD, was referred to as George J. Cooley. ■



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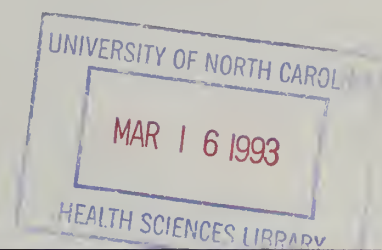


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News for Members of the Ohio State Medical Association

SRF begins refund process

In Brief: Claim forms are scheduled to be mailed next month to physicians who are eligible for SRF refunds. You have 180 days to return the forms. Checks could be mailed in mid-November.

Steps to liquidate the \$45 million Stabilization Reserve Fund have finally begun, and the approximately 26,000-28,000 physicians who are owed refunds should watch their mailboxes for claim forms, which they will need to fill out and return as soon as possible. Physicians have 180 days from the date that the notification was sent to return the form.

Don't expect to receive your refund until mid-November, however.

"The Department of Insurance wants to make sure that everyone who has the right to a refund has the opportunity to file a claim," says Herb Gillen, OSMA's senior executive director, in explaining the reason for the lengthy delay.

See **SRF** page 2



Walter A. Reiling, Jr., MD, left, OSMA President-Elect, discusses his plans for a health-reform task force with Jack Summers, MD, center, and John F. Kroner, Jr., MD.

OSMA will develop own health-reform plan

In Brief: A new task force, appointed by OSMA's president, will produce Ohio physicians' own health-care reform plan that will serve as the foundation of OSMA advocacy for 1994 and beyond.

While Ohio legislators wait for Washington to make the next move on health-care reform, the OSMA intends to move ahead

quickly on drafting its own reform measures for the state.

President Stanley J. Lucas, MD has formed a new Task Force on Health-Care Reform, which will be responsible for drafting an original, comprehensive plan for reforming Ohio's health-care system. President-Elect Walter A. Reiling, Jr., MD has been named its chair.

See **Task Force** page 2

PICO to adjust reserves

A just-released actuarial study has revealed that the Physicians Insurance Company of Ohio will need to adjust its reserves when it files its 1992 year-end financial reports with the Ohio Department of Insurance. This information, presented to the PICO board at its regular February 20th meeting, has temporarily halted the negotiations between the OSMA and PICO. The two organizations have been negotiating since the beginning of February to come to terms regarding the possible purchase by PICO of OSMA's Class B shares in the company.

The information came as a surprise to OSMA's officers and Council, as it did to

the PICO board. Both organizations agree that the need for PICO to increase its reserves is not related to the possible sale of its stock.

"Since the actuarial information was preliminary, both PICO and the OSMA need some time to evaluate it before proceeding with the negotiations," according to Brent Mulgrew, executive director of the OSMA.

"We expect to know the full extent of the proposed adjustment in early March," he adds. "At that time, both parties will make a decision on how negotiations can continue." ■

Inside

■ **SUICIDE:** Jack Kevorkian, MD may not be coming to Ohio, but state legislators are preparing bills banning assisted suicide just in case. **3**



Dr. Kevorkian

■ **MEDICAID:** There's a reason Ohio doctors are refusing to treat Medicaid patients. This doctor explains why. **8**

■ **MILLIONS SAVED:** Sign up for OSMA's Workers' Comp program like these physicians have done and you, too, could save a bundle. **9**

■ **HB 478 CHALLENGED:** These Ohio physicians will try to sue the state over the new ban on balance billing. **14**

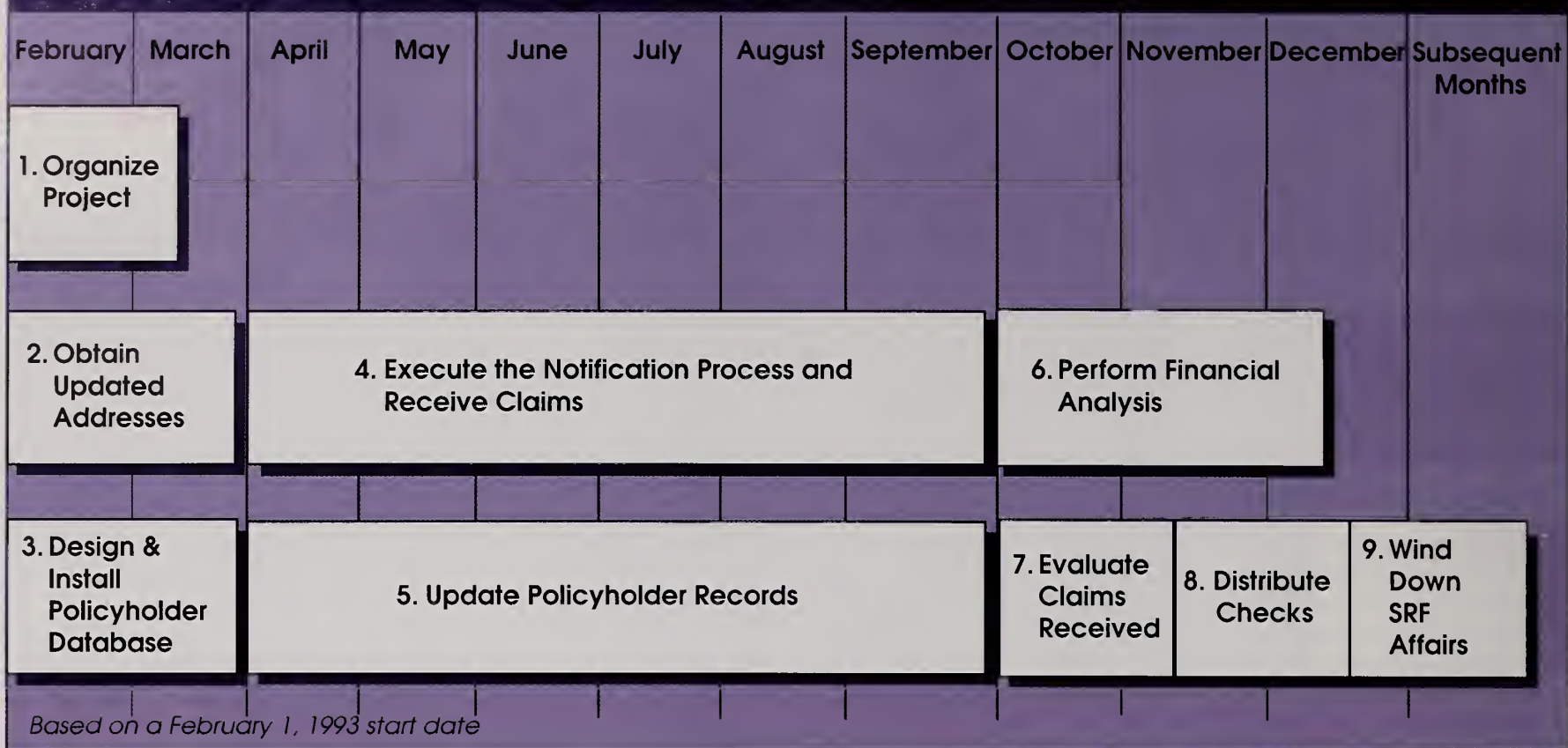
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SRF Preliminary Timeline



SRF...From page 1

The Department of Insurance will verify each claim, and will determine the amount to be refunded, based on what the physician paid into the fund, and the amount of interest owed.

The Stabilization Reserve Fund was created in the mid-'70s as a

supplemental fund to pay excess medical liability claims that the state Joint Underwriting Authority fund couldn't pay. All physicians who practiced in Ohio and carried medical liability insurance coverage during the years 1976-1979 were required to contribute to SRF.

The OSMA initiated legislative action to set in motion the process

of refunding monies to eligible physicians – and, last year, association staff members worked with the Department of Insurance to identify potential recipients of the SRF refunds.

In addition to the official notification that the JUA is sending by certified mail to all eligible policyholders, legal notices will also appear in newspapers for a

three-week period.

A related article, featuring questions and answers about the SRF disbursement, can be found on page 12 of this issue. If you have further questions, or need more information about the refund process, call Herb Gillen at the OSMA, 1-(800) 766-OSMA.

Task Force...From page 1

"It's clear there will be major health-care reform on both the federal and state level," says Dr. Reiling, "so it's essential that physicians have ready a health-care reform package that will outline our own views of what the future of health care should look like in this state."

A proposal is a proactive step, and one the OSMA needs to take to maintain its effectiveness at the Statehouse, says OSMA Legislative Director John Van Doorn. Without their own credible plan to offer legislators, Ohio physicians are placed, as they have been for years, in the awkward position of reacting to legislation that has been formulated by someone else.

An OSMA plan will show legislators some movement forward on this important issue, says Dr. Reiling. "But that plan

must address cost-containment and financing or else legislators won't take it seriously," he says.

FRESH START

While Dr. Reiling believes that the Health Access America plan, developed by the American Medical Association and touted as medicine's answer to health-care reform for the past several years is a good program, he also believes that there are a couple of reasons the OSMA will want to develop its own agenda. First: It's not easy to overlay the AMA's entire, multifaceted plan on top of a state program. Certain tenants of Health Access America work in Ohio; others don't. "It's much more advantageous to be able to pick and choose for legislation only those items that will work," says Dr. Reiling. Second, the AMA plan lacks credibility with Ohio legislators, who view it as somewhat self-serving.

That's not to say, however, that the new OSMA task force will ignore the AMA plan. "I have no doubt that many of these things we propose will come from the Health Access program," says Dr. Reiling.

MEMBERS ARE BROAD MIX

The task force, which was still being formed at press time, will be composed of members who represent a broad range of specialty, type of practice and geographic location.

"Medicine needs to present a unified front to Ohio legislators, so we need the full support of every specialty society as well as from OSMA members," says Dr. Reiling. Many specialties have their own legislative agendas, but by recruiting members for the task force through the specialty societies, the OSMA hopes to work toward one agenda that speaks for all Ohio physicians.

"The only person we don't necessarily want to see on our task force is someone who already has in mind a health-care plan. Task force members need to be flexible and open to all suggestions," says Dr. Reiling.

TIME FRAME FOR PLAN

The OSMA believes there is a six- to nine-month window of opportunity to put together its legislative proposal.

Task force members, then, will dedicate two full days a month toward hammering out a reform agenda. The first meeting was scheduled at the end of February. The plan should be completed by late summer. OSMA Council will receive periodic updates, and the OSMA House of Delegates will also receive a report from the task force at its Annual Meeting in May.

Watch *OHIO Medicine* for future reports on this group.

Assisted suicide could be made felony

In Brief: OSMA favors legislation banning assisted suicide, but does not want language that limits the practice of medicine.

Jack Kevorkian, MD, the Michigan pathologist who has assisted 15 people to commit suicide, has announced that he is no longer considering a move to Ohio. But, just in case he changes his mind, Ohio legislators are working to enact a law against assisted suicide.

"The OSMA has a policy against voluntary, active euthanasia, so we are sympathetic with the legislation," says Cynthia Snyder, JD, associate director of OSMA's Department of Legislation. Still, the OSMA is monitoring the language of these bills carefully to ensure that legislators do not unnecessarily infringe on the practice of medicine in their efforts to stop Dr. Kevorkian.

The four bills that have been introduced on this subject are:

- **Senate Bill 7** – Grace Drake, R-Solon
- **Senate Bill 9** – Betty Montgomery, R-Perrysburg
- **House Bill 18** – Dale Van

Vyven, R-Sharonville

- **Senate Bill 24** – Bob Nettle, D-Barberton

Senate Bill 7 and House Bill 18 are identical. They would make it a felony if a person, with knowledge that another intends to commit suicide, does any of the following:

- Provides the physical means to commit suicide.
- Participates in any physical act by which a person commits suicide.
- Counsels someone who is planning to commit suicide.
- Otherwise aids or abets someone to commit suicide.

Senate Bill 9 doesn't include "counseling" within the definition of assisted suicide.

Exceptions are included in all four bills for the withholding or withdrawal of life-sustaining treatment under the terms of Ohio's living will and durable power of attorney for health-care law, and for palliative care that may hasten or increase the risk of death.



At press time, Michigan retired pathologist Jack Kevorkian, MD, had assisted 15 patients in committing suicide.

Sen. Nettle has taken a slightly different approach, patterning his bill after the new Michigan law. It would create a 25-member commission to study all aspects of the assisted suicide issue. A report would be due by January 1995. Pending the recommendations in the report, assisted suicide would constitute a fourth-degree felony.

CONCERNS EXPRESSED

The OSMA has expressed concern with regard to two of the provisions in SB 7 and HB 18. Psychiatrists, for example, often counsel someone who is planning

to commit suicide, and because physicians are frequently requested by patients to write prescriptions for a 30-day supply of medication for insurance purposes, they could, conceivably, provide the physical means to commit suicide. The OSMA expects these concerns to be addressed by legislators as they draft a final bill.

"We expect the Legislature to act quickly on this issue," says Snyder. *OHIO Medicine* will notify you of the outcome.

(See related story on page 6.)

Governor makes Medicaid reform top priority

In January, *OHIO Medicine* presented a story and chart that described the large portion Medicaid occupies in the state budget. That's why it comes as little surprise that Gov. George Voinovich has made Medicaid reform one of his top legislative priorities in 1993.

Senate Bill 1, introduced by Richard Finan (R-Cincinnati), and House Bill 31, sponsored by Paul Jones (D-Ravenna), both attempt to wrestle with this issue.

Presently, most reforms are aimed at the nursing home component, which accounts for almost half of the Medicaid budget. The proposed legislation would divert Medicaid patients from

nursing homes and other institutions and place them in less-expensive home-care settings.

"The OSMA's goal in all of this

is to convince legislators and the governor that Medicaid reimbursements to physicians are grossly inadequate," says John Van Doorn, director of OSMA's Department of Legislation.

"These reimbursements are less

than the actual cost of providing care, and unless the Ohio Legislature addresses this problem, it is likely that there will be fewer

FRAUD INVESTIGATED

Low reimbursements aren't the only thing that might prompt

physicians to stop seeing Medicaid patients, however. Any stepped-up efforts to pinpoint physicians' fraudulent actions might convince innocent physicians that the hassles just aren't worth it. (See "Second Opinion" in the Commentary section.)

According to a report in the *Cleveland Plain Dealer*, Ohio Medicaid officials reviewed 523 doctors, hospitals and pharmacies in the program last year and audited 124 of them. As a result, the state recovered \$2.6 million in improper payments. While that total may seem an incentive for more fraud investigations, it actually represents less than one-tenth of 1% of the Medicaid budget. Nevertheless, it may be money that the state now feels it can no longer afford to ignore.

State Legislators

These are the names and addresses of Ohio's delegates.

Governor

Address the letter to: The Honorable George Voinovich
Governor of Ohio
77 South High St., Riffe Center
Columbus, OH 43266-0601

Salutation should read: Dear Governor Voinovich

State Senator

Address the letter to: The Honorable (full name)
Ohio Senate, Statehouse
Columbus, OH 43266-0604

Salutation should read: Dear Senator (surname)

State Representative

Address the letter to: The Honorable (full name)
Ohio House of Representatives
77 South High St., Riffe Center
Columbus, OH 43266-0603

Salutation should read: Dear Representative (surname)

Congressional Delegation

These are the names, numbers and addresses of Ohio's congressional delegates.

President of the United States

Address the letter to: The President, The White House
Washington, D.C. 20500

Salutation should read: Dear Mr. President

U.S. Senator

Address the letter to: The Honorable (full name)
U.S. Senate
Washington, D.C. 20510

Salutation should read: Dear Senator (surname)

U.S. Representative

Address the letter to: The Honorable (full name)
U.S. House of Representatives
Washington, D.C. 20515

Salutation should read: Dear Representative (surname)

U.S. Representatives:

Douglas Applegate, 18th District – (202) 225-6285

John Boehner, 8th District – (202) 225-6205

Sherrod Brown, 13th District – (202) 225-3401

Eric Fingerhut, 19th District – (202) 225-5731

Paul Gillmor, 5th District – (202) 225-6405

Tony Hall, 3rd District – (202) 225-6465

Martin Hoke, 10th District – (202) 225-5871

Dave Hobson, 7th District – (202) 225-4324

Marcy Kaptur, 9th District – (202) 225-4146

John Kasich, 12th District – (202) 225-5355

David Mann, 1st District – (202) 225-2216

Mike Oxley, 4th District – (202) 225-2676

Deborah Pryce, 15th District – (202) 225-2015

Ralph Regula, 16th District – (202) 225-3876

Thomas Sawyer, 14th District – (202) 225-5231

Louis Stokes, 11th District – (202) 225-7032

Ted Strickland, 6th District – (202) 225-5705

James Traficant, 17th District – (202) 225-5261

(The 2nd District seat is vacant; a special election is scheduled for May 4.)

U.S. Senators:

Howard Metzenbaum, (202) 224-2315

John Glenn, (202) 224-3353

What's in store for medicine? A Clinton health-care primer

Two approaches under consideration by the new presidential health-care panel are managed competition and global budgets. Both concepts are explained more fully below:

MANAGED COMPETITION

Definition: A proposed health insurance system where health benefit plans compete in a regulated environment. One example of managed competition, the Jackson Hole Group's plan, would have sponsors (employers, government agencies, labor groups, etc.) buy insurance through purchasing groups, contributing a set amount toward insurance for the individuals they represent. The contribution would be equal to the cost of the least expensive plan providing coverage for a basic set of benefits.

Pros and cons: In theory, man-

aged competition leaves physician choice of practice structure intact. Physicians would be able to contract with whatever type of plans they found most desirable or could form their own. It's likely, however, that new incentives and penalties could cause a shift in the distribution of coverage from traditional coverage to HMP/PPO-type plans. In addition, government regulations under managed competition systems may favor managed care plans.

GLOBAL BUDGETS

Definition: Limits on total expenditures for health services to predetermined amounts within a specific period. Some health system reform proposals call for global budgets to set a national ceiling on health-care spending in an attempt to control costs.

Problems: There are a number

of fundamental problems with this concept. For example:

- **Arbitrary** – There is no predictable or reliable method of determining the appropriate level of spending.
- **Incomplete** – They don't specify what mechanisms would be used to determine maximum expenditures for specific services.
- **Unpredictable consequences** – The consequences of the limits for patients and physicians are unpredictable and, in all likelihood, would be detrimental. The risks in putting bureaucratic constraints on an industry bigger than automotive, aerospace and computer manufacturing combined are enormous.
- **Rationing implicit** – Patients would be at risk of exclusion

from appropriate medical care as budget limits were reached. Physicians' roles as patient advocates would be compromised as physicians were called upon to act as rationing agents for the government.

- **Administrative burden** – Global budgets will lead to a substantial increase in the regulatory and administrative burdens placed on health-care delivery. This approach diverts health-care dollars from patient care and more health dollars are spent on administrative expenses.
- **Bureaucratic** – This concept will add to the regulatory burden of government. Most proposals call for the states to take responsibility for budget allocation. This will require states to develop and staff elaborate data systems to plan and administer the global budget. ■

PRESIDENT'S PERSPECTIVES

Caring for the poor is our duty

One of the more interesting reports to surface at the American Medical Association meeting in Nashville this past December was Report C of the Council on Judicial and Ethical Affairs, "Caring for the Poor." It carefully reviews physicians' individual ethical responsibilities to care for the ill and needy from the time of Hippocrates to the AMA's first code of ethics, which states "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded."

CEJA fully recognizes, however, philanthropy of individual physicians cannot, in itself, cure the complicated and complex series of problems facing society in regard to access of care for all Americans (even excluding the medical problems of the people of the world).

The report describes a sick person as uniquely vulnerable to exploitation; the practice of medicine as a privilege, although certainly a well-earned privilege; and the physician as a patient ad-

vocate dedicated to the patient's welfare.

It is abundantly clear to all of us in practice that extraordinary burdens of government regulation and legislation; economic pressures of third-party payors; society's desire for "everything possible - forget the cost"; and medical liability issues place a tremendous influence on a physician and his or her time. It has been very difficult for a physician in recent years to individually respond to the poor as in the past.

Despite these circumstances, as recommended in the report, it behooves all of us to proactively continue to contribute our services whenever appropriate. Continue to see indigent patients in your office without charge; donate your time at free clinics; participate in fund raising; and help design and lobby for more efficient programs to provide care for the poor.

Over the years, there have been many programs in Ohio for the free care of the poor. These pro-

grams have undergone change under the influence of new circumstances, and differing demand for free services.

However, let us not allow the current frustrations and doctor-bashing turn us away from a long-standing professional responsibility to care for the indigent sick. Our voluntary response to these needs will continue to set physicians apart from other professions. Despite the negativity we now experience, physicians can maintain a high level of esteem, which we have earned.

Let us continue to work together in the care of the poor. It is not out of fashion! ■



Stanley J. Lucas, MD

News & Views

Optometry redefined

Last fall, the American Optometric Association adopted a new definition for its profession. It now defines its practitioners as follows: Doctors of optometry are independent primary health-care providers who specialize in the examination, diagnosis, treatment, and management of diseases and disorders of the visual system, the eye and associated structures, as well as the diagnosis of related systemic conditions.

Makes you wonder how the group would define "ophthalmologist."

Editor -

Do you have a comment about something you've read or an opinion you'd like to share with your colleagues?

Write to:

Editor, OHIO Medicine
1500 Lake Shore Dr.
Columbus, OH 43204-3824

OHIO Medicine

News for Members of the Ohio State Medical Association

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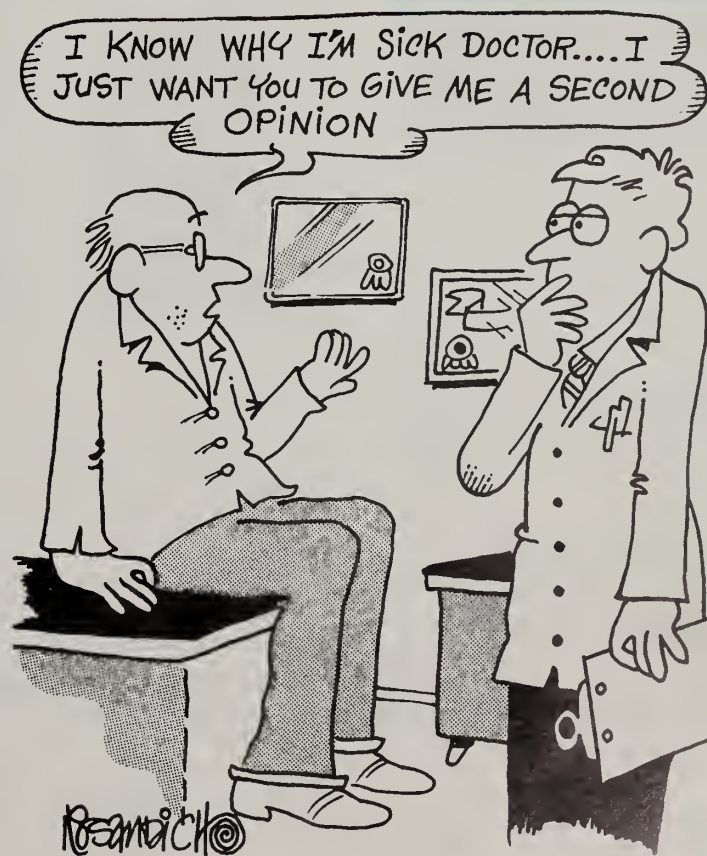
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OSMA welcomes letters to the editor: OHIO Medicine, Executive Editor (800) 766-OSMA 1500 Lake Shore Drive Columbus, Ohio 43204-3824



AUXILIARY REPORT

Come "Communicate at the Capital"

Auxilians all over Ohio have been busy working on health-promotion projects to ensure improvement of the quality of life through health education. This terrific group of volunteers has raised thousands of dollars for medically related scholarships in our immediate communities and AMA-ERF, as well as raising charitable funds for community projects.

The OSMA-A Board of Directors passed three resolutions on specific health issues, which are being reviewed by an OSMA panel of physicians. Upon the approval of the physician panel, the resolutions will be submitted to AMA-A for consideration at the annual meeting in June. One resolution deals with breast cancer awareness, and the other two resolutions deal with the effects of smoking on pregnancy and smoking in teens. The resolutions have educational components and action plans for future community projects. Commendation goes to the Montgomery

County Auxiliary for the submission of the three health resolutions.

legislation in Vermont from Gov. Howard Dean, MD; learn how to communicate with one's legis-

address begins at 9:15. Other speakers are state representatives Rose Vesper, JoAnn Davidson, Mike

Stinziano, Paul Jones and state Sen. Grace Drake.

Lunch will be with members

of the Senate and House

health

committees.

Van Doorn will brief participants prior to appointments with legislators. All activities take place in the Riffe Center, 77 South High Street. Registration is \$25. Please call Carol Wenger at (614) 486-2401. ■



Sara Rich, President

Learn the latest developments in health-care legislation coming before the Ohio Legislature.

Legislative efforts of the state auxiliaries swing into action on March 10 when they assemble in Columbus for "Communicating at the Capital." Participants will: learn the latest developments in health-care legislation coming before the Ohio Legislature; learn the major health-care items that will be discussed before the health committees of the Senate and House; learn about health-reform

lators; talk to members of the Senate and House health committees at lunch; share views on the issues; receive an overall briefing by John Van Doorn, director of OSMA's Department of Legislation; and make appointments in the afternoon to talk with legislators.

The activities begin at 8:45 a.m. with registration and a continental breakfast. Vermont Gov. Dean's

SPEAKOUT

Should physicians have the right to assist with patient suicides?



Jerry Hammon,
MD
West Minton

"I think that perhaps a few physicians have been doing this for years...I feel the patient should have a right to decide when enough is enough and legally be able to seek some assistance."



Al May, MD
Marion

"Speaking as a practicing pediatrician whose professional life has been dedicated to the preservation and maintenance of health and life, I find it hard to reconcile medical practice with anything that would actively assist in the willful termination of life."



Ruby Knucklos,
MD
Toledo

"No, but I think each patient should at least die with dignity with the least amount of pain. Physicians should help alleviate the patient's suffering."



Robert Brodell,
MD
Warren

"Compassion and empathy are crucial attitudes of a caring physician. Physician-assisted suicide is not a rational component of these expressions of physician concern. No physician should have the right to purposely end their patients' lives."

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LETTERS TO THE EDITOR

Discrimination not intended

To the Editor:

The ad cited by Dr. N.N. Patel in his letter to the January 1993 issue of *OHIO Medicine* was indeed inappropriately worded. However, this was inadvertent. It was not intended to exclude graduates of international medical schools, but to specify graduates of ACGME-approved training programs or their equivalent.

Riverside Hospitals is an equal opportunity employer. Both its administration and medical staff leadership are committed to diversity in its work force and medical staff. We are sorry if Dr. Patel or any other reader has been offended by this ad.

JOHN J. PICKEN, MD

Medical Director

Riverside Methodist Hospitals
Columbus

HB 478 should specify "criminal intent"

To the Editor:

Where was our representation when House Bill 478 was passed? As the bill presently reads, physicians who do not want to accept assignment are forced to accept assignment because a simple phrase was not thought important enough to be added to the legislation. Why was not a phrase stating, "Fines will be leveled if criminal intent is determined," rather than have a blanket fine system that does not allow for clerical errors? I feel the OSMA has done the membership a great disservice in not addressing this particular issue.

EDMOND W. GARDNER, MD

Columbus

Dear Dr. Gardner:

In early versions of HB 478, the penalty for violation of the ban on balance billing Medicare patients was forfeiture of one's license to practice medicine. In later drafts it became a criminal penalty with fines, prison sentences and loss of license.

At last, OSMA persuaded legislators to reduce these to civil penalties that are the same as the fines levied under federal law for overcharging Medicare patients. In addition, the director of the Ohio Department of Health has the discretion to waive these fines altogether. No crimes are committed and no licenses will be revoked.

JOHN VAN DOORN

Director, OSMA Department of Legislation

Non-MDs shouldn't be allowed to prescribe

To the Editor:

I have nothing against nurses; some of my best friends are nurses. But after reading the story, "Pilot Project Gives Nurses the Right to Treat," (January 1993), I wonder what is next for the American physician. What else can happen to us?

It's difficult enough for physicians to diagnose and treat, with all the years of training they've had to undergo, but to permit someone with lesser knowledge to do so is dangerous and alarming.

Who's next? The massotherapist and the naturopaths? If this be the case, why not let them endure the training we had to do?

I know many busy physicians who feel that nurse practitioners and physicians' assistants are valuable tools in their practice, but who would be uncomfortable in this position. I'm not saying there are not good nurses – there are many. I'm not saying that there aren't nurses who know as much as many physicians – there probably are, or at least some who think they do...but in the long run, I personally feel it is a slap in the face to permit individuals with much less training to do the job that I sometimes feel very inadequate at myself – not because I'm incompetent, but because I'm human.

The health-care field is becoming inundated with those wishing to take care of patients and enjoy the supposedly large fees that family physicians charge. What a laugh! As for nurses prescribing medications for patients, only under the direct supervision of a physician, this, too, has run into problems in several reported cases.

I will probably get nasty letters from nurses telling me that I am behind the times, and that I feel threatened by them, etc., etc. So be it.

Final diagnosis: I don't believe that anyone should prescribe drugs until they have had the training that physicians must have...and that includes pharmacists.

DOMINIC B. BRUNE, MD

Zanesville

OSU has public health program

To the Editor:

With regard to your article "Ohio may offer public health class" (January 1993), you incorrectly stated: "...there isn't a single program in the state that teaches public health."

The Ohio State University College of Medicine, and the graduate school of the Ohio State University offer a three-year-old program leading to the degree of Master of Public Health. This is the only program of its kind approved by the Ohio Board of Regents, and the only one in Ohio accredited nationally by the Council for Education in Public Health. Actually, the Department of Preventive Medicine of OSU has conducted graduate programs leading to the MS and PhD degrees and residencies in preventive medicine and public health for nearly 40 years.

As an outgrowth of the graduate program of OSU's Department of Preventive Medicine, plans are now in progress for the development of a school of public health at Ohio State University. Discussions are under way with other universities in Ohio to develop a consortium of interest drawing on academic strengths that exist throughout the state. The core courses required by a school of public health are already being offered at OSU, and are accredited by the Council for Education in Public Health. The existing offerings will be expanded in conjunction with other universities. The objective is to prepare professionals for the field of public health and to conduct research that will promote public health, disease prevention and health promotion in our rapidly changing health-care system.

MARTIN D. KELLER, MD, PhD

Professor, Department of Preventive Medicine, OSU
Columbus

Editor's Note: *OHIO Medicine* inadvertently printed the word "program" when the word "school" should have been used. We regret the error.

SECOND OPINION

Why doctors are refusing Medicaid patients

By William B. Rogers, MD

Last December, the *Akron Beacon-Journal* ran a sensational front-page headline entitled: "Feeding frenzy at Medicaid trough." The subtitles read: "A small percentage of doctors statewide making a bundle with near impunity," "Several cut deals on overbilling," and "Questionable practices going unchecked."

Whether these charges are true or not, it was especially disturbing to see an accompanying article entitled: "Three area doctors questioned on billings," thus making them appear guilty by association.

AKRON DOCTOR TARGETED

The case of one of those doctors, B.V. Hegde, MD of Kent, was particularly upsetting because, when you checked the small print, he was not charged with any fraud or poor medical practice, but only with overbilling. Now, if Medicaid did not approve of his billings, why didn't

they tell him so after only two or three months rather than wait several years to dictate that his way of charging was unacceptable to them, and then subject him to a large fine?

Because of regulations, red tape and tactics like that one, there

doctors only enough to cover their overhead, one would assume those pediatricians have taken that stand for mercenary reasons, and that physicians should have a greater obligation to care for our country's poor. Such an assumption would be

percentage of children in their practice is small enough they will continue to accept new patients and suffer the dictates of Medicaid. There are still

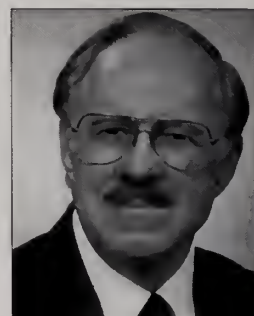
hospital and public health clinics available, and Medicaid

parents will continue to run their children to our hospital emergency rooms anytime, day or night, for the most trivial of concerns.

To quote one pediatrician who formerly accepted any new Medicaid patient: "Many an ADC parent has said to me that, 'When I took my child to the emergency room, I really didn't think it was too serious, but it never hurts to be sure. Besides, it didn't cost me anything!'" We probably can't blame those parents who think such care is free; they don't stop to think that it is our taxes that pay those bills. That is one reason Medicaid costs have climbed so high that a billion dollars in new taxes has now been imposed on Ohioans.

But friends of Dr. Hegde are not surprised Medicaid could find no evidence of fraud in his billings, and they are proud to know him. He is only guilty of practicing good medical care, taking care of all those who sought his expertise, and failing to recognize that — right or wrong — you do things the way bureaucrats want them done.

William B. Rogers, MD, Cuyahoga Falls, is a pediatrician and a member of the OHIO Medicine Advisory Committee.



Dr. Rogers, MD

We should no more blame this problem on doctors than we should blame farmers for failing to feed all of the starving.

have been only two pediatricians in the city of Akron and its immediate suburbs, representing a half-million people, who would accept any ADC patient who phoned, looking for a doctor. Now, those two doctors are going to join the majority who refuse to accept new Medicaid patients.

PAY NOT AN INCENTIVE

Since Medicaid reimburses

wrong. To care for Medicaid patients is a social problem of society. We should no more blame this medical problem on doctors than we should blame the construction industry for the lack of housing for the homeless, or farmers for failing to feed all of the starving.

Up until several decades ago, doctors cared for any ill person, regardless of ability to pay. They took turns treating the hospitalized in clinics, treating the ambulatory ill. Whether for illness or surgery, no sick person was ever refused surgical or medical care. The only compensation doctors expected was the patient's partnership in training doctors for future generations.

BUREAUCRATS TO BLAME

Our politicians, however, did not feel this was satisfactory, so they started socializing medicine. That is now involving us in the most expensive, bankruptcy-bound debt our country has ever known, and everyone admits the results are a failure.

But ill Medicaid children will still be adequately cared for. The numerous doctors who accepted Medicaid in the past will continue to care for those same patients in the future. There will still be those doctors whose

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Group rating program saves physicians \$2.5 million

If you are looking for ways to trim your practice cost consider enrolling in the OSMA's Workers' Compensation Group Rating Program.

A number of OSMA members – 3,900 at last count – will save a combined \$2.5 million in their

A group of 40 Marion doctors saved \$32,000.

annual Workers' Compensation premiums in 1993-1994, the second year of this valuable membership program. *OHIO Medicine* talked with some of the participants to see how the program benefited them.

Pat Hertenstein, officer manager with Springfield Health Care Center, liked the program because of the savings. "It was definitely a win-win situation for us," says Hertenstein. The center, which specializes in internal medicine, realized a savings of \$3,000 for their four physicians and 15-member staff. "Even though two of our four physicians had to become members of OSMA to qualify, the savings was well worth the added membership dues," says Hertenstein.

At the Holzer Clinic in Gallipolis a very substantial amount

was saved. "We felt the pooling concept made a lot of sense. Plus we were impressed with the individuals who approached us about joining; they were on top of the subject," says Roger Carter, assistant administrator at Holzer. "This was the first such program we heard about that offered our clinic such a substantial amount of savings," he adds. The OSMA's Workers' Compensation Group Rating Program came along at the same time the Holzer Clinic was looking into a self-funding program. The clinic employs 65 physicians and 375 support staff.

It was also the financial savings of the program that attracted Mark Freyhof, director of finance at the F.C. Smith Clinic in Marion. The multispecialty group of more than 40 physicians will save approximately \$32,000 by participating.

"I think it's great. I'm glad to see it," says Freyhof. "The idea of being tossed into a bigger pool of practitioners and lessening the risk was attractive to us."

If you're already enrolled, your application will be automatically filed for the third year of the program. If you aren't yet enrolled, watch for a special application in April's *OHIO Medicine*.

If you have questions, contact Jerry Campbell, director of the Department of Development and Member Services, at 1-(800) 766-OSMA. ■

Domestic violence kits available

In answer to requests, the OSMA Department of Communications is seeking physician volunteers from around the state to serve as speakers on the subject of domestic violence.

To assist the speakers, the OSMA has put together a speaker's kit. The kit includes: two sample speeches – one geared to the general public and one specifically for physicians – plus a slide presentation. These kits will

be mailed free to members upon request.

For more information contact Connie Roth Lechleitner, OSMA Communications Department, 1-(800) 766-OSMA.

The domestic violence campaign, which kicked off in October, was the first of a three-part series. The issue of child abuse will be addressed in April, followed by elder abuse in the fall. ■



Metro Executives Meet

Executives of the metro county medical societies met recently at the OSMA headquarters to discuss concerns of physicians from their areas. John Van Doorn, OSMA's director of Legislation, presented an overview on the health-care reform legislation. From left: Shirley Bee, Summit; Eleanor Pershing, Mahoning; Nancy Adams, Stark; Judy Khoii, Greene; and Bill Carbone, Franklin.

County Society Notes

Lorain County...The Medication Safety Program kicked off last October when 10,000 photodegradable bags were hung from doorknobs, and 5,000 fliers and posters proclaimed "It's In the Bag." The program has met with outstanding success, says County Executive Director Eileen Wiersma.

Lake County...During HEALTHFEST '92, a communitywide health fair held at Lakeland Community College last September, the Lake County Medical Society sponsored its second annual no-smoking contest. "I'm Too Smart to Start" was open to all students grades 1-5. Program chair was Joseph Koelliker, MD, a Willoughby family practitioner, who has led a one-man campaign against smoking for the past 30 years.

Montgomery County...It took almost two decades, but the match was lit and the mortgage burned in a ceremony at the Montgomery County Medical Society last October. Past presidents and treasurers were invited back to witness this momentous occasion. Herman I. Abromowitz, MD was extremely pleased, since it was during his presidency that the purchase agreement was finalized and the mortgage terms signed. County Executive Director Dick Tapia shared some anecdotal reminiscences before lighting the match.

Cuyahoga County..."I admire and respect doctors as tremendous human beings. Their humanity has impressed me to no end," says a recent participant in the mini-internship program. Since April 1989, 46 "interns" and more than 100 academy physicians have participated in this program, which is a way of opening communications and fostering understanding between leaders in the community and the medical profession. Those physicians who are interested in hosting an intern (April 18-20 and November 14-16) should call Shirlee Leathers at (216) 229-2200. ■

Committee endorses guidelines to reduce HIV risk in sports setting

In Brief: The Ohio High School Athletic Association has made a ruling to help prevent the contraction of the HIV virus in sports. The new ruling was put to the test Jan. 15 in Columbus when one of the players was hit in the face and sustained a bloody nose.

In the last few months considerable media attention has been given to HIV infection as it relates to sports. So naturally, the topic was on the agenda at a recent OSMA Joint Advisory Committee on Sports Medicine meeting.

It seems the Ohio High School Athletic Association (OHSAA) has received numerous inquiries about the potential risk for contracting HIV/AIDS or other infectious diseases during sports par-

and other skin surfaces if contaminated with blood or other body fluids.

3. Bloodied portion of uniform must be properly disinfected or the uniform must be changed before athlete/official may return to playing field.
4. Clean all blood-contaminated surfaces and equipment with a solution made from one ounce per gallon of household bleach or other recommended disinfectants.
5. Practice proper disposal procedures to prevent injuries caused by needles, scalpels and other sharp instruments.
6. To minimize the need for emergency mouth-to-mouth contact during resuscitation, mouthpieces, resuscitation bags or other ventilation devices should be available for use.
7. Trainers/coaches with bleeding or oozing skin condition should refrain from all direct athletic care.
8. Contaminated towels must be properly disposed of or disinfected.
9. Follow acceptable guidelines in the immediate control of bleeding when handling bloody dressings, mouthguards and other articles containing body fluids.
10. Bleeding or oozing from wounds should be contained so that blood products cannot be transmitted to another person.

The ruling was put to the test Jan. 15 at a Walnut Ridge (Columbus) boys basketball game when a player was hit in the face and sustained a bloody nose. The officials stopped the game so that the player could change his uniform before going back onto the playing field. ■

Officials recently stopped a basketball game when a player sustained a bloody nose.

ticipation. OHSAA felt it necessary to address the issue and called on the committee for input.

While experts say the possibility of HIV transmission occurring during athletic competition is very remote, there is a risk that other blood-borne infectious diseases can be transmitted.

COMMITTEE GUIDELINES

The committee reviewed the OHSAA's list of communicable disease precautions and endorsed, with some recommendations, the following guidelines:

1. Routine use of gloves or other precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids.
2. Immediately wash hands

CALENDAR

The OSMA has planned the following practice management workshops for 1993. Watch for more information on these workshops in future issues of *OHIO Medicine*.

One-Day Workshop

Managed Care – You will learn the key strategies to profitably negotiate contracts and how to organize your practice to fulfill the contracts efficiently. This workshop will also give you a better understanding of the various delivery systems and payment mechanisms.

- Mar. 2 Marriott, Cincinnati
- Mar. 3 Holiday Inn, I-675, Fairborn
- Mar. 4 Concourse Hotel, Columbus
- Mar. 16 Dana Center at MCO/Hilton, Toledo
- Mar. 17 Sheraton City Center, Cleveland
- Mar. 18 Parke Hotel, Canton

Medical Office Management Institute (MOMI)

These workshops have been designed for medical office managers, supervisors and key employees. Some offices have used these workshops to upgrade the skills of established personnel as well as for indoctrination of new employees. The following five-day workshops can be taken in any combination:

- effective personnel management techniques;
- improving your managerial effectiveness;
- patient flow management;
- financial management;
- improving your third-party reimbursement and coding

June 28-July 2, Cleveland Stouffer Tower City Plaza, Cleveland
August 2-6, Cincinnati Kings Island Inn, Kings Island, Ohio

How to Run a More Profitable Practice

This one-day workshop is designed to show you the steps to a smarter, leaner and more profitable practice. Learn where your trouble spots are and how to bring them under control.

- Sept. 28 Marriott Airport, Cleveland
- Sept. 29 Concourse Hotel, Columbus
- Sept. 30 Cincinnati Marriott, Cincinnati

Maximizing Your Collection Results

This one-day course is designed for the experienced office manager, billing supervisor and physician manager. The course deals with all aspects of the collection process. Learn to identify the problem, correct it and make certain it doesn't return. The workshop approaches the collections function from the management perspective.

- Oct. 12 Dana Center at MCO/Hilton, Toledo
- Oct. 13 Sheraton City Center, Cleveland
- Oct. 14 Parke Hotel, Canton
- Oct. 26 Concourse Hotel, Columbus
- Oct. 27 Stouffers, Dayton
- Oct. 28 Sheraton, Springdale, Cincinnati

Colleagues

Ira A. Abrahamson, Jr., MD, Cincinnati, was elected to the Board of Directors of Cincinnati Rotary 17, the seventh largest Rotary in the world, and was named the Paul Harris Fellow as outstanding Rotarian in the Cincinnati area for 1992.

Frank W. Cianciolo, MD, Madeira, was named president of the Academy of Medicine of Cincinnati. Dr. Cianciolo is vice president of medical services for Cincinnati Bell and a professor of family medicine at the University of Cincinnati.



Dr. Cianciolo

Kathryn Clausen, MD, was named chair of the department of pathology at The Ohio State University.

Patrick Convery, MD, was appointed medical director of Lake Hospital System's sports medicine program at Lake Rehabilitation and Wellness Center in Mentor.

John Dobson, MD, Springfield, was appointed chair of Community Hospital's orthopedics department.

John Drstvensek, MD, Columbus, was appointed director of the emergency services program at Park Medical Center.

Stewart Dunsker, MD, Cincinnati, was named 1992 Neurosurgeon of the Year by the Ohio State Neurological Society. Dr. Dunsker is a member of the Mayfield Neurological Institute, director of the neurology departments at Christ Hospital and Jewish Hospital, and a professor of neurosurgery at the University of Cincinnati Medical Center.



Dr. Dunsker

Ray W. Gifford, Jr., MD, Cleveland, was given the 1992

Master Teacher Award of the Ohio Chapter of the American College of Physicians. Dr. Gifford is vice-chair of the Division of Medicine at Cleveland Clinic Foundation.

Manolo Mapa, MD, Chester, W.Va., was named Physician of

the Year by Ohio Valley Health Services. Dr. Mapa chairs the internal medicine department at City Hospital in East Liverpool.



Dr. Mapa

Grant K. Varian, MD, Bellefontaine, was named corporate medical director of Peer Review Systems. Dr. Varian is chief of staff at Mary Rutan Hospital in Bellefontaine and past president of the Logan County Medical Society. ■

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Physicians' questions about SRF refunds answered

Q. Who is eligible for an SRF refund?

A. All physicians who practiced in Ohio and carried medical liability insurance coverage during the years 1976-1979. These physicians were required to contribute to the Stabilization Reserve Fund.

Q. How much money will be returned?

A. The amount you originally paid into the fund, plus interest. The Department of Insurance will determine the amount due each policyholder.

Q. How can I claim my refund?

A. If you are eligible to receive a refund, you should receive, by certified mail from the Joint Underwriting Authority (which managed the SRF), a claim form. You must complete the form and return it within 180 days of the date that the form was mailed. *OHIO Medicine* has plans to publish this claim form as soon as it becomes available for those who are eligible for a refund but did not receive a form.

Q. When will the money be returned?

A. A tentative schedule, developed by the JUA, puts

checks in the mail by mid-November.

Q. Will I receive the refund, or will it go to my corporation or the hospital for which I work?

A. According to Victor Goodman, JD, the SRF's legal counsel, the party that was named as the policyholder will receive the refund. If the policyholder is Jane Smith, MD, Dr. Smith will receive the refund. If the policyholder is the Smith Clinic, then the refund will go to the Smith Clinic. If the policyholder is the Smith Clinic, "which has paid on behalf of Dr. Jane Smith and Dr. John Smith," the refund will be shared by Drs. Jane and John Smith.

Q. Will I have to declare my

refund on my 1993 tax return?

A. Both Victor Goodman and Norman Beals, director of the JUA and SRF, say that question is best answered by your own tax accountant. A 1099 form will be sent along with each refund check, and your interest will be noted separately from the amount of money that you have contributed to the fund, notes Beals. Whether or not you must pay taxes may depend on whether or not you claimed a deduction on the payment – but check with your accountant on this and any other specific tax questions you may have.

Q. Where may I get further information on the refund process, or ask further questions?

A. Contact Herb Gillen, OSMA's senior executive director, at 1-(800) 766-OSMA. ■

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- Newer Treatment Options for Depression
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(614) 566-5605 or (800) 257-3900.

Registration: Deadline April 30



First-Quarter Council Report

ProviderLink...Councilors agreed to endorse a new electronic service, ProviderLink, which will be offered to OSMA members through the Minnesota-based United Health Care Corporation, the organization that includes two Ohio HMOs – Western Ohio and Columbus' PHP – among its holdings. The service will allow physicians to file claims and communicate other information electronically to the HMOs and other insurers. Anyone wishing more information about the service should contact Jerry Campbell, OSMA's Department of Development and Member Services.

Legislative Update...Since House Bill 478, the health-care reform bill, was passed, a number of members have expressed concern over the ban on balance billing Medicare patients and the \$500 overcharge amendment. To a lesser extent, comments have also been received against the nurses' pilot project. While Ohio implements the

provisions in this bill and awaits further health-care reform cues from Washington, the OSMA will form a task force that will develop a health reform proposal of its own. The OSMA intends to offer this proposal to state legislators later this year.

Cancer Committee...Councilors have endorsed the Ohio Cancer Pain Initiative for one year and will re-evaluate this program after that period of time. They also endorsed a cancer screening checklist, designed for the use of primary care physicians.

Legal Update...The OSMA will request permission to file an amicus brief in litigation involving radiologists at Cleveland's St. Luke's/MetroHealth Medical Center, who are disputing the hospital's attempt to employ them, rather than negotiate separate service contracts. The OSMA is opposed to the corporate practice of medicine, and any attempt to lift the state's current ban on the practice. ■

OSMA salutes...

In Brief: OSMA salutes doctors who are voluntarily helping in their communities.

David Zemsky, MD, Hamilton... Retired from private practice, Dr. Zemsky now spends time helping second-graders at Marshall Elementary School learn to read. He also volunteers at the Miami University Art Museum, where he created the program, "Adventures in Art." The program travels to schools and teaches children about various printing methods.

Victoria Cargill, MD, Cleveland... Dr. Cargill's personally funded organization, "Stopping AIDS Is My Mission," has brought educational programs about the dangers of spreading AIDS to 11,000 Cleveland-area students. Her group is now developing a program that will involve teens in teaching their peers about safe sex and AIDS.

The Lincoln Heights Health Center, Cincinnati... This center, which recently celebrated its 25th birthday, has grown from a part-time immunization clinic to a full-fledged medical operation, serving 50,000 patients a year at two sites. Located in an African-American community, the clinic was started to provide primary care to children, and to give residents someplace to go for health care, other than the emergency room.

The Association of Philippine Physicians in Ohio, Cleveland... Established in 1972, the APPO is a society of 200 active Philippine members in various medical specialties practicing in Ohio, primarily in the greater Cleveland area and Lorain County. The group recently completed its seventh volunteer medical mission to help the people of the Philippines. Although there are more than 100 Philippine-American physician organizations in the U.S., the APPO was the first to undertake a med-

ical and surgical mission to the Philippines.

Robert Slagle, MD, Cincinnati... Since 1987, Dr. Slagle, a plastic surgeon, has traveled with a medical team of about 10-20 people to Peru to help correct the

cleft lips, palates and other deformities of the country's children.

James Quilty, MD and Charles Dillard, MD... The starving African nation of Somalia has received help recently from both

these Ohio doctors. Dr. Quilty, a Columbus pediatrician, provided care to Somali children and helped teach adults about basic health practices, while Dr. Dillard, Cincinnati, helped distribute 15 tons of medical supplies to Somali clinics. ■

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Proposed suit to challenge Medicare balance billing law

In Brief: A group of Ohio physicians hopes to raise enough money to fight a newly enacted state law that bans balance billing of Medicare patients.

When House Bill 478 passed the Ohio Legislature late last year, it included – despite the OSMA's best efforts – a provision that prohibited physicians from balance billing their Medicare patients.

Obviously, a number of Ohio physicians were upset by the news – but a small group has taken their concern one step further. This group, organized by Carl Wehri, MD of Delphos, intends to file a lawsuit to enjoin the state from enforcing its balance billing ban. How successful will they be?

Odds makers would call it a long shot at best. Katrina English, JD, director of OSMA's Department of Legal Services, said that three other states have already attempted to go through the courts to overturn similar bans on balance billing, and all three states have been unsuccessful.

"Federal courts in three different jurisdictions have rejected the suits, and in one case the U.S. Supreme Court has refused to hear an appeal," she says. In fact, the American Medical Association, which had provided support to the three states, has indicated that it would be reluctant to assist any new endeavors along this line.

None of this discourages Dr. Wehri, however. "We think the law that was passed here in Ohio is different from the laws passed in the other states. For example, the Massachusetts law ties that state's ban on balance billing to licensure," he says.

PHYSICIAN-PATIENT LINK

More than the differences in the law, however, Dr. Wehri believes that Ohio's lawsuit will succeed because his group is trying an approach that no other state has tried before – involving the patients.

"We believe the ban on balance billing significantly impairs the

physician-patient contract," says Dr. Wehri. So, in addition to "raising the consciousness of physicians around the state," patients are also being asked to sign petitions supporting the suit. Physicians have been asked to place these petitions in their waiting rooms.

Proponents of the Ohio litigation point out that a similar approach to involve patients in a suit proved successful in New Jersey recently (*Stewart v.*

"We believe the ban on balance billing significantly impairs the physician/patient contract."

Sullivan) when Medicare patients and their physicians sued the Health Care Financing Administration over their right to contract privately for services.

English points out, however, that the decision in the New Jersey case has limited application, and nothing in the decision prevents Congress from passing a law expressly preventing private contracting, or the Secretary of Health and Human Services from announcing a formal policy that prohibits it.

Even if this should happen, and the plaintiffs returned to District Court to reopen the order – Ohio is not in the same federal jurisdiction as New Jersey and could face an entirely different outcome than the one that is ultimately decided by New Jersey courts. Physicians who wish to engage in private contracting may be wise to secure a waiver from the patient, attesting that he or she would not later seek Medicare reimbursement, says English, and they are further advised to seek counsel before making any moves in this area.

MONEY HAS BEEN RAISED

According to Dr. Wehri, however, \$30,000 has already been raised for the lawsuit through the

Ohio Physician Defense Foundation, an organization that was formed last year with the intention of raising money to help defray the legal costs of physicians whom the foundation believed had been wrongfully charged by the state medical board. Monies raised now by the foundation will go toward funding the suit. Dr. Wehri predicts \$75,000 will be needed before any legal action can be filed.

"Besides, there's more than a

legal concern here," Dr. Wehri continues. In order for physicians to comply with the law, they need to ask patients about their income levels – a question that, Dr. Wehri says, may make some physicians uncomfortable.

The new law permits physicians to balance bill a patient who earns a gross annual income greater than \$40,860, but the physician must first ask the patient to verify that their income exceeds this amount. (The February issue of *OHIO Medicine* carried a form

requesting income information that physicians may give their patients to complete for this purpose.)

The bill's opponents offer this intrusion into patients' affairs as another reason for the provision to be removed.



Dr. Wehri

FOUGHT LEGISLATIVELY FIRST

Dr. Wehri says he worked actively with the OSMA to remove the ban on balance billing provision from HB 478 before it was enacted. Once he saw that the provision would remain, he began to investigate the possibility of a suit.

John Van Doorn, OSMA's director of Legislation, said that a corrective bill to HB 478 may yet materialize, but there is little chance that a substantive change, like deletion of the ban on balance billing, would be made. "There may be some technical changes, but there is not a chance that the ban on balance billing Medicare patients will be removed," Van Doorn says. ■

Malpractice misperceived

A study of 8,231 malpractice cases, filed in New Jersey over the last 15 years, found that doctors' perception of malpractice litigation as a major factor in health-care costs isn't necessarily so. Published in the *Annals of Internal Medicine*, the study determined:

- Juries found in favor of doctors in 76% of the 976 cases where there was a jury verdict.
- Patients won payments in

3,514 cases. Of those, the doctors' actions were judged by doctors of similar training and experience as indefensible in 1,813 cases and defensible in 1,054. Quality of care was unclear in 647 cases.

- Payment was made in 91% of cases where the doctor's conduct was considered substandard; in 21% of cases where the doctor's care was considered defensible. ■

Should a physician breach patient confidentiality?

In Brief: Physicians may think that physician/patient confidentiality is sacred, but there is one exception.

A Toledo area murder case has challenged traditional views of attorney/client confidentiality, making doctors uneasy that the ruling might affect the physician/patient relationship.

In that case, a man accused of murder admitted as much to his attorney shortly after the shooting. Under normal circumstances,

Court ruling, known as the Post decision, which states: "We hold that a client's disclosure to a third party of communications made pursuant to the attorney-client

privilege breaches the confidentiality underlying the privilege and constitutes waiver thereof." The ruling is broad, they say, and it never suggests physicians or

others would be immune.

For now, physicians should continue to honor physician/patient confidentiality. But if you should become embroiled in a case similar to the Toledo attorney's, the best advice is: Call your lawyer. ■

A patient can breach his or her confidentiality by revealing private information to a third party.

the conversation would be legally protected under attorney/client confidentiality laws. But the court ordered the attorney to testify in his client's case because it believed the accused told others of the conversation, thus breaching any attorney/client confidentiality. The attorney, who refused to testify, was jailed.

In theory, the same could happen to physicians, psychologists, clergy and social workers, since state law says conversations between those professionals and a person is protected unless the person reveals the information to a third party or unless the court believes the person revealed the information.

It is a longstanding tradition that physicians not reveal conversations with a patient without the patient's consent, and that they are generally granted immunity from revealing such information given in confidence.

But some believe a physician could be cited for contempt of court, much as was the case with the Toledo attorney. They cite as reason the original Supreme

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Judge allows comatose Akron teen to die

An Akron family's battle over their comatose daughter's fate has finally ended.

At odds were a divorced couple who disagreed over whether or not their 15-year-old daughter's food and hydration tubes should be removed.

In late October, Carla Myers suffered severe head injuries after a rented limousine she was riding in was struck by another car. After undergoing several surgeries at Akron General Medical Center, she was transferred to Edwin Shaw Hospital, which specializes in rehabilitation treatment.

RECOVERY RULED OUT

It was there that physicians told her father, Tim Myers, that although his daughter was breathing on her own, she was in a chronic vegetative state and would not recover. And it was then that Tim Myers, who is Carla's legal guardian, agreed to let physicians remove Carla's food and hydration tubes.

Doctors told Tim Myers his daughter would die within seven to 10 days, but on the sixth day,

Carla's tubes were reinserted after her mother, Robin Myers, protested, saying the measure was inhumane and that her daughter should be allowed to die naturally.

Ohio's living will law doesn't address teens.

HOSPITAL POLICY VAGUE

Although the hospital is not commenting on the case, their policy on the subject is as follows: "It is rarely ethically permissible to withhold food and water from a patient, but careful consideration must be given to requests involving patients in persistent vegetative states. Decisions to remove life-sustaining measures are made after careful evaluation by two physicians and by consensus of the doctors and the patient's family members." There are no provisions on what to do when parents disagree.

Ohio's living will law does not

affect the case, because although it allows families of patients in a persistent vegetative state to petition probate court for an order to remove food and water, it does not specifically address juvenile patients.

Eventually, the courts appointed a guardian – Barbara Patterson, a nurse, psychologist and lawyer – to assess Carla's condition. In mid-January, she said in a memorandum to Summit County Probate Judge Bill Spicer that it would not be in Carla's best interest to "be maintained in her present irreversible, untreatable, incurable and persistent vegetative state."

Both parents agreed with Patterson's recommendation, as did Spicer, who ruled January 29 that Carla Myers should be allowed to die. Her food and water were removed Feb. 1.

Soon after, however, a Barberton couple filed to adopt Carla, saying they would care for her in their home. Spicer rejected their request, ruling that the couple didn't meet legal requirements.

The teen died Feb. 7. ■

Update

Malpractice award overturned

A three-judge Court of Appeals panel (8th District) recently overturned a \$6.25 million malpractice award, saying that the damages were excessive. The panel then ordered a new trial to determine compensatory damages, and eliminated the \$3 million punitive awards altogether. The eight-member jury had found Harry Figgie, III, MD liable for a Cleveland-area woman's death. The panel agreed, however, with the jury's finding of medical malpractice by Dr. Figgie.

Convictions thrown out

The Ohio Supreme Court threw out 300 felony drug convictions of Thomas H. McCarthy, a former Dayton doctor who prescribed diet pills to his patients. The Supreme Court's decision followed a similar reversal made by the Ohio 2nd District Court of Appeals in 1991, which found that the Common Pleas Court judge's instructions to the jury were not defined appropriately.

"Love doctor" case continues

The Ohio State Medical Board says its four-year investigation into whether other doctors knew about former Dayton gynecologist James Burt, and failed to report his controversial "love surgery" is still open, although no action has yet been taken by the board. The investigation focuses on a 16-year-old state law that requires doctors to file a formal complaint with the board if they suspect another doctor of poor practice. Court records indicate several doctors assisted Burt or treated his patients, but no Ohio physician has been charged with violating the law.

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When to use practice parameters

Practice parameters have been a part of medicine for some time now, but with the current focus on the cost and quality of health care, their use is likely to become prevalent.

Practice parameters, which are basically strategies for managing a patient's care, describe a range of possible approaches to diagnosing, managing or preventing disease. So far, more than 45 physician organizations nationwide have developed about 1,500 practice parameters covering a variety of clinical issues.

Using parameters may actually help control liability risks.

The question for most physicians becomes, "Should I be using practice parameters in my practice?" In Ohio physicians are not required by law to follow parameters, says Katrina English, director of the Department of Legal Services, though some states mandate the use of practice parameters in certain circumstances. "Practice parameters have been effective in reducing health-care costs and physician malpractice liability," English notes. At the national level, practice parameters are often included in health-care reform proposals. Organized medicine is working diligently to ensure that physicians are involved in formulating the parameters, and that the medical community keeps primary control over their development and application.

LEGAL IMPLICATIONS

In most cases physicians are not legally required to follow practice parameters. However, their use does not create liabilities; won't increase exposure to malpractice suits; and may actually help control liability risks.

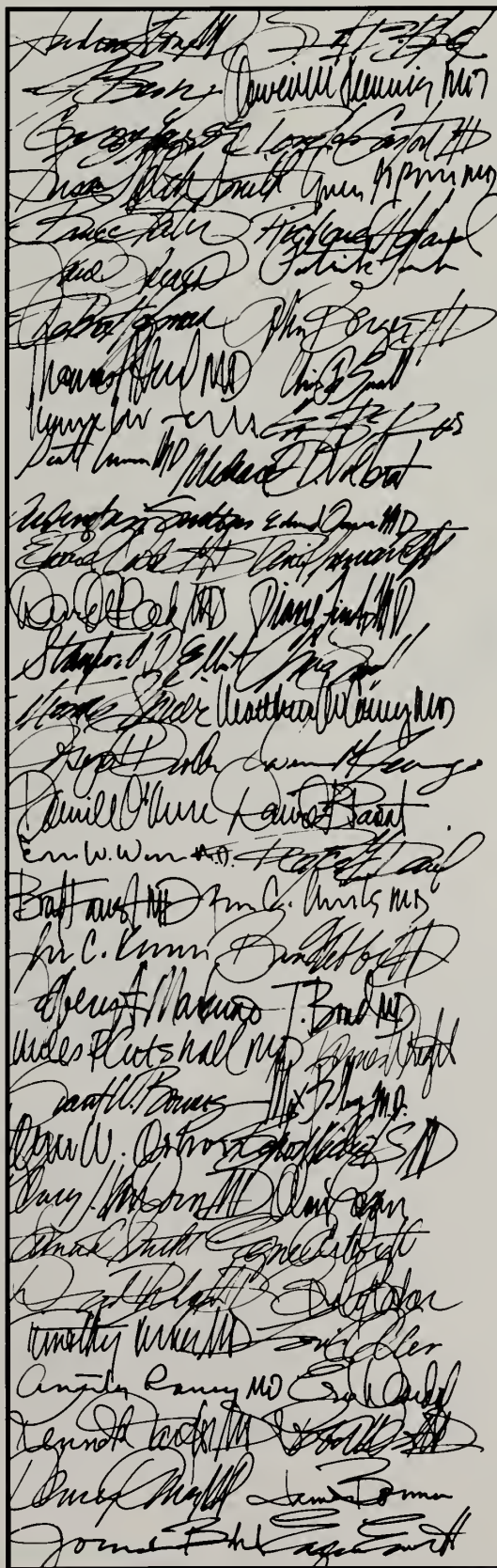
Because practice parameters

can become a source of evidence in a malpractice suit, it's best if physicians are aware of practice parameters before treating a patient. That way physicians can

explain their chosen course of treatment – why they did or did not follow practice parameters – should the need arise.

Physicians with questions about practice parameters should request a copy of "The Directory of Practice Parameters." Published annually by the AMA, it

provides information on how to obtain specific parameters. The AMA also publishes "Practice Parameters Update" three times a year to update physicians on parameters that are recently developed, revised or rescinded. To order, call the AMA at 1-(800) 621-8335. ■



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Abortion informed consent on hold

The abortion informed consent law, scheduled to become effective in May of last year, remains embroiled in the judicial system.

In January, in its year-end report on state legislation, *OHIO Medicine* reported that HB 108,

currently on appeal. The legal challenge was brought by pro-choice groups, and the law is being defended by the Ohio Attorney General.

"This law would place certain legal requirements on physicians who counsel women on abortion, as well as those performing the procedure," says Cynthia Snyder, associate director of OSMA's Department of Legislation. "It requires individual physician counseling, a 24-hour waiting period and distribution of state-provided information on fetal development and abortion alternatives.

"The law remains on the books," says Snyder, "but because it's been declared unconstitutional and because litigation is going on, the requirements are not currently in force."

OHIO Medicine will keep you updated on the status of the litigation. ■

Ongoing litigation is keeping the law from being enforced.

"Informed Consent for Abortion," had a May 1992 effective date.

While this is technically true, enforcement of the law was precluded by a Franklin County Court of Common Pleas decision that several provisions were unconstitutional. The case is

Home office write-offs tricky business

If you typically write off your home office as a tax deduction each April, you should know about a recent U.S. Supreme Court decision that may put an abrupt end to that practice.

The case brought before the court involved an anesthesiologist, Nader E. Soliman, MD, who performs his primary work in hospitals. Since he's not on staff at any hospital, and not provided with any hospital office space, he maintains an office at home, where he books patients, bills them, and maintains their records. While the Supreme Court conceded that Dr. Soliman needed an office, it told him that his tax deductions for a home office were not legitimate because his patients do not visit him there. It's not his principal place of business.

In deciding this case, the Supreme Court, in effect, threw out an extension of the home office

law that had been affirmed by the Fourth U.S. Circuit Court of Appeals in Richmond, Virginia. That extension allowed taxpayers to deduct their home offices, even if most of their business was conducted elsewhere, as long as the home office was essential to the business, a substantial amount of time was spent there and there was nowhere else to accomplish necessary paperwork.

Now, the only taxpayers who may legitimately deduct home office expenses are those who see patients in their home or use the office as a principal place of business.

Although taxpayers are not required to amend old returns, they will owe back taxes and interest on their previous deductions if audited.

If you have questions, talk to your tax adviser before taking those home office deductions. ■

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OSHA Fined Me \$88,000

An Ohio physician tells his story

Editor's note: Last month, *OHIO Medicine* reported that we had learned of an Ohio physician who had been fined \$35,000 by the Occupational Safety and Health Administration (OSHA) for non-compliance with its blood-borne pathogen regulations. We were wrong. In fact, \$35,000 was the result of negotiating down an

original assessment of \$88,000. As far as we know, this is the largest amount ever assessed a physician. The physician involved was willing to tell his story to *OHIO Medicine*, on the record, so that other physicians might learn from his mistakes.

For Miamisburg physician S. Vincent Anand, MD, the OSHA nightmare began in the middle of October.

"An inspector showed up at my office, presented his identification and explained that he had come to perform an inspection," says Dr. Anand.

The inspection had been prompted by a letter from an employee who had complained to OSHA that Dr. Anand had failed to train his employees on the proper handling of materials that placed them at risk of exposure to blood-borne pathogens.

THE FIRST MISTAKE

Like many physicians with hectic practices, Dr. Anand had left it to an employee to bring his practice into compliance with OSHA regulations when they were released last year.

He assumed his office was in compliance, though he had never been shown – and had never asked to see – any of the material that OSHA had sent regarding its blood-borne pathogen requirements.

"I thought everything was all right, that we were in compliance," says Dr. Anand. The inspector spent a day and a half interviewing six of Dr. Anand's employees. After the interviews, the inspector told Dr. Anand that he wanted to discuss the violations. Two of Dr. Anand's employees sat down with the inspector, but Dr. Anand declined. He believed his employees would handle the situation.

Later, he learned that one of the employees who had sat in on the interview had been rude to the inspector. "I immediately called the OSHA office and apologized and arranged to meet with the inspector in his Cincinnati office to discuss the violations." He learned that almost none of the OSHA regulations had been put into place by his employees.

QUICK COMPLIANCE

Within a week of that meeting, Dr. Anand had come into compliance with 90% of the regulations. "Training my employees took a little longer to complete," he says.

Despite the hasty compliance, however, the Cincinnati inspector notified Dr. Anand the second week of November that he should return to OSHA offices to discuss "significant penalties"...specifically an \$88,000 fine.

"I got on the phone and searched for a lawyer who was familiar with and willing to take on a case involving OSHA non-compliance," says Dr. Anand. He finally located an attorney in Santa Ana, California who flew in, overnight, for Dr. Anand's arranged meeting with the OSHA inspector.

"(My employees) assured me we were in compliance ...I believed them."



Dr. Anand

There they learned that the \$88,000 fine was a total of individual fines charged for each infraction. "The largest was \$14,000 for failure to vaccinate my employees," recalls Dr. Anand. Eventually, the sum was whittled to \$35,000, to be paid over a nine-month period. Dr. Anand figures that legal fees and the costs of bringing his practice into compliance with the OSHA regulations amounted to an additional \$10,000.

"I very nearly had to declare bankruptcy and close my practice," he says.

It was a costly way to learn that physicians must take seriously the OSHA regulations and be personally responsible for bringing their practices into OSHA compliance – a lesson he hopes to deliver, now, to other physicians at considerably lower rates.

"Personally, I don't agree with some of the regulations, and I fail to understand why OSHA must levy such huge fines, but I don't hold a grudge against OSHA or its inspectors. They're just doing their job. However, I do hold a grudge against legislators and others who force such regulations on physicians."

Dr. Anand says he does not want to have his experience viewed as a horror story.

"I'm not the sort of person who is devastated by such experiences," he says. "It's life. I move on."

Dr. Anand says he will conduct future seminars to educate other physicians how to come into compliance with OSHA regulations. Those interested should call Dr. Anand at (513) 438-8711. The OSMA Department of Legal Services also can provide information on OSHA regulations. Call 1-(800) 766-OSMA.

CLIA laboratory regulations eased

The AMA and other specialty societies lobbied heavily and won a battle to ease clinical lab regulations to some extent. As published in the Jan. 19, 1993, *Federal Register*, a new category of lab testing for physician-performed microscopy procedures was established, and one more test was added to the waived category.

Tests in the new category are considered "moderately complex" under Clinical Laboratory Improvement Amendments (CLIA), but physicians will be able to perform six microscopic exams in their office without being subject to routine CLIA inspections.

The government does, however, have the right to inspect the lab if it receives a complaint or has reason to believe the lab is in violation of CLIA requirements.

NEW CATEGORY

Physician-performed microscopy applies to:

- Wet mounts, including preparations for vaginal, cervical or skin specimens
- KOH preparations
- Pinworm preparations
- Fern tests

- Urine sediment exams
- Postcoital exams

The tests may only be performed by doctors of medicine, osteopathy or podiatry on patients in their own medical practices. Labs with nonphysicians performing these tests cannot take advantage of the new category.

Some physicians have expressed concern that the number

of tests should be expanded, while others believe nonphysicians, technicians and nurses should be able to perform the tests.

WAIVED CATEGORY

One more test has also been added to the waived category, increasing the number of waived tests to nine. The one new waived test includes automated hemoglobin tests using single analyte

instruments with self-reagent interaction and direct measurement and readout. Physicians performing only waived tests are not subject to CLIA inspections.

Although the published regulation is final, comments will be accepted until March 22. Send to: Department of Health and Human Services, Attn: HSQ-202-FC; P.O. Box 26676, Baltimore, MD 21207. ■

Registration and Inspection Fees For Moderate & High-Complexity Labs

| Schedule | Number of Annual Lab Tests | Registration | Inspection |
|----------|--|--------------|------------|
| A* | 2,000 or fewer tests | \$100 | \$300 |
| A | 2,001-10,000 tests | \$100 | \$840 |
| B | < 10,000 and 4+ specialties | \$100 | \$1,120 |
| C | 10,001-25,000 tests | \$100 | \$1,400 |
| D | 10,001-25,000 tests and 4+ specialties | \$350 | \$1,645 |
| E | 25,001-50,000 tests | \$350 | \$1,890 |
| F | 50,001-75,000 tests | \$350 | \$2,135 |
| G | 75,001-100,000 tests | \$350 | \$2,380 |
| H | 100,001-500,000 tests | \$600 | \$2,625 |
| I | 500,001-1,000,000 tests | \$600 | \$2,870 |
| J | More than 1,000,000 tests | \$600 | \$3,115 |

* This represents the minimum fees for registration and inspection for any lab regardless of the number of tests performed.

Note: The registration and inspection fees are payable every two years. The fees for inspection are estimates based on average times anticipated and a fee of \$35 per hour. If the actual time is more or less the inspection fees will vary.

Source: Health Care Financing Administration (HCFA)

CLIA inspection fees may be lowered for some physicians

Physicians should carefully review the newest information being mailed out by HCFA on the CLIA program. The CLIA User Fee Remittance Coupons for collection of the cost of a federal or state inspection, which will be conducted to verify laboratory compliance with CLIA standards, are in the mail.

Physicians who are affected by recent revisions to the CLIA regulations regarding the waived category and the newly intro-

duced Physician Performed Microscopy Category (see story above), may not have to pay the full amount shown on the coupon. HCFA has provided instructions with the coupon to assist physicians who may wish to make a change to their CLIA certificate.

Questions may be directed to the HCFA/CLIA program at (410) 290-5850 or the OSMA Ombudsman staff 1-(800) 766-OSMA. ■

Ask the Ombudsman

Q. Does prohibition against balance billing mean no money should be collected from the Medicare patient?

A. Physicians must continue to collect certain amounts from their Medicare patients.

Physicians who accept assignment from Medicare should collect from the Medicare patient the 20% coinsurance amount of the approved charges by Medicare, any unmet portion of the annual deductible and for any services that are considered noncovered

under the Medicare program.

Physicians who do not accept assignment from Medicare should collect no more than the Medicare Nonpar Allowed amount from patients who have an annual income of less than \$40,860, and no more than their Medicare limiting charge from patients who have an annual income of more than \$40,860.

If you have questions contact the Ombudsman staff directly at 1-(800) 766-OSMA. ■

HCFA being asked to extend Medicare sign-up deadline

An advisory panel of physicians from Nationwide-Medicare is spearheading an effort to convince the Health Care Financing Administration (HCFA) to give Ohio physicians another opportunity to become a participating physician under the Medicare program.

Many physicians let the December 31, 1992 deadline for sign-up pass without realizing that House Bill 478, Ohio's health-care reform legislation, makes participating in Medicare more financially attractive and less burdensome administratively. The law, which was signed by the governor on Jan. 14, became effective immediately. Under the new law, physicians may not balance bill Medicare patients whose income is less than 600% of the federal poverty level (approximately \$40,000/yr.). Physicians who violate this law, even inadvertently, are subject to harsh fines.

Since Medicare-participating physicians receive a higher reimbursement rate than non-participating physicians in return for agreeing not to balance bill,

Nonparticipating physicians are being asked to respond.

some physicians are finding that it makes economic sense to participate. In mid-December, the OSMA issued an alert to its members, advising them that they may want to reconsider their decision regarding participation. During the last week of December Nationwide-Medicare received more than 1,500 signed participating agreements from physicians.

At the same time, the OSMA contacted HCFA to inquire about the possibility of extending the December 31 deadline for physicians who needed more time to make this important decision. HCFA indicated that an extension was not possible.

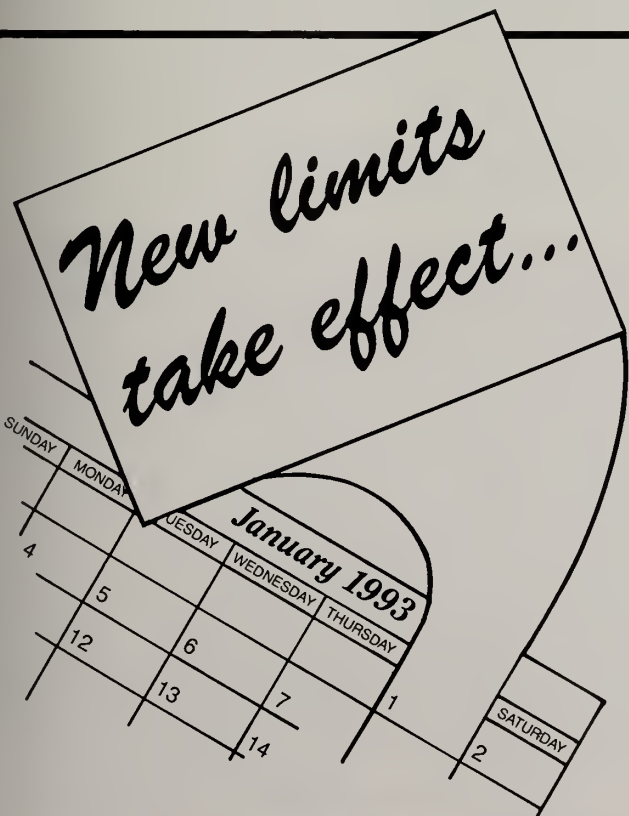
However, the Ohio Carrier Advisory Committee of Nationwide-Medicare is hopeful that HCFA will reconsider its decision. This committee, co-chaired by William P. Sawyer, MD, is asking the approximately 4,000 Ohio non-participating physicians who would like to participate in Medicare to sign the Medicare participation agreement and either fax or send it to the Medicare offices. Physicians who no longer have a copy of the participating agreement may simply send a letter of intent, stating their wish to become a participating physician.

The fax number is (614) 249-3732. The address is: William P.

Sawyer, MD, Co-Chair, CAC, P.O. Box 16788, Columbus, Ohio 43216. Dr. Sawyer is asking physicians to send this information as soon as possible. He indicated in a letter to nonparticipating physicians that if a significant number of physicians respond to this request, Medicare may be able to convince HCFA to grant an extension since they will be able to demonstrate that there are a number of nonparticipating physicians who wish to participate.

Participation rates for physicians in Ohio rose from 63.4% in 1992 to 84.7% in 1993, according to carrier figures. In addition, the carrier indicated that more than 95% of all physician claims are now submitted on an assigned basis.

Physicians who have questions about their participation status or how the new law may affect their ability to bill Medicare patients should contact the OSMA Ombudsman Department at 1-(800) 766-OSMA. ■



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Physicians given options for complying with CLIA

In Brief: Physicians may choose either federal inspection or private accreditation to comply with CLIA '88.

Many physicians have expressed confusion and utter frustration in trying to comply with the Clinical Laboratories Improvement Amendments (CLIA) of 1988 regulations.

The intention of the new clinical lab amendments was not to frustrate physicians, but rather to ensure the quality and proficiency of clinical laboratories and persons who conduct such tests.

Over the next two years, 200,000 U.S. labs will prepare for CLIA inspectors who will begin knocking on physicians' doors. The initial inspections will be educational. If a lab does not meet standards, it will be asked to come into compliance. Sanctions will only apply if conditions pose a serious problem to a patient's health.

OHIO Medicine reported last month that physicians would have until March 1 to obtain a CLIA registration number. If you have not done this, expect to hear from your Medicare carrier

indicating that the federal records do not show a CLIA number on file for you.

Physicians who had not previously applied for a CLIA registration number may use HCFA forms 114 and 116 to apply for the number. On those forms, physicians are offered the option of choosing between private and federal accreditation. If the physician chooses federal, he or she will automatically receive the federal inspection materials. If the physician chooses private, that particular source must be contacted.

OPTIONS AVAILABLE

Many physicians are unaware that they do have an option. To meet CLIA '88 requirements physicians may:

- 1) Participate in the federal program with biennial on-site inspections, or
- 2) Obtain accreditation from HCFA-approved private, non-profit, peer-reviewed accreditation program

All laboratories enrolled in private accreditation must register with HCFA by completing the

HCFA 114 and 116 survey forms and paying a registration fee.

PRIVATE ACCREDITATION

The only private accreditation program is the Commission on Office Laboratory Accreditation (COLA) program sponsored by the American Academy of Family Physicians, the American Medical Association, the American Society of Internal Medicine and the College of American Pathologists. This is a voluntary, non-profit accreditation and education program for physician office labs.

Those physicians who enroll in the COLA program will not be billed by HCFA for an inspection or placed on the list of facilities to be inspected by state and federal surveyors.

For some physicians, seeking COLA accreditation may be more cost-effective than the HCFA inspection program, according to Stephen Kroger, MD, chief executive officer of COLA. For example, in Ohio a two-physician practice performing 12,000 tests per year in four specialties of testing will pay a \$1,200 biennial fee to COLA, plus an \$82 validation fee, for a total of \$1,282, compared to the cost of the HCFA inspection of \$1,889. This is a savings of \$607.

HCFA's fees are based on the volume of testing and number of specialties of testing, whereas COLA's fees are based on the number of physicians using the laboratory and the number of specialties of testing performed.

PROFICIENCY TESTING

However, COLA is not a proficiency testing program. Physicians who participate in either the federal program or COLA need to purchase a proficiency testing package from an approved proficiency testing program. Proficiency testing is mandated by CLIA as a method to evaluate the quality of a laboratory's performance.

"Check out the private accreditation programs and proficiency testing programs just as you would any contract," says Deborah Bahnsen, JD, staff counsel to OSMA's Ombudsman Department. ■

CLIA mandates proficiency testing

Each laboratory performing tests of moderate or high complexity is required to enroll in an approved proficiency testing program for each specialty and subspecialty for which it seeks certification.

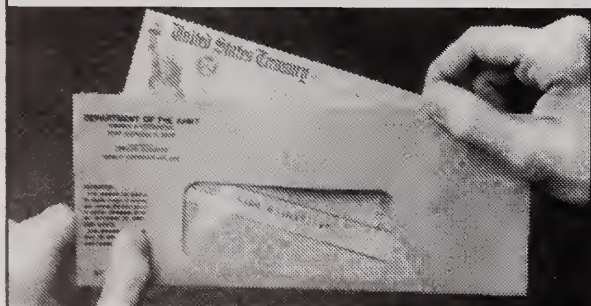
The following proficiency testing services have been approved by CLIA:

- American Association of Bioanalysts, (800) 234-5315
- American Proficiency Institute, (800) 333-0958
- College of American Pathologists, (800) 323-4040
- American Society of Internal Medicine's Medical Laboratory Evaluation (MLE), (800) 338-2746

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Highlights from the 8th international AIDS conference

Editor's Note: This article was submitted by Michael F. Para, MD, an AIDS specialist with Ohio State University Hospitals.

PATHOGENESIS

Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Disease, presented an overview of how he believed HIV leads to AIDS. A new finding in his report shows that soon after a person is infected, there is a marked rise in virus in the blood. The body then markedly suppresses this virus and a long, asymptomatic phase occurs. What Dr. Fauci has now found is that, during that asymptomatic phase, the virus is growing in the lymph node. Once the virus reaches a high enough number, small areas in the lymph gland begin to die off and more infected T4 cells enter the blood stream. With time, most of the infected cells in the lymph node die off or travel into the blood stream. The implication of this research is that persons may need to be treated earlier in their infection.

It has become increasingly clear that a person is initially infected

by one strain of virus. Each time a virus multiplies in the body, it undergoes slight mutations. With

resistant to ddI. If the person continued to take their ddI, the ddI-resistant strain would even-

Researchers have found that during the asymptomatic phase, the virus is growing in the lymph node.

time, the daughter (or son) viruses are more numerous and more diversified. These viruses are still very similar to each other, but they each possess slightly different properties. Some strains might grow faster, some might be drug-resistant, some might resist the body's attempt to kill it, and some might spread to the brain. Which strain grows the best and becomes the predominant strain in any particular person depends on many factors. For example, if the person is receiving AZT, the strain that had mutated and become AZT-resistant would grow the best. If this person were to stop AZT and start ddI, one of the AZT-resistant viruses might mutate further and become

usually multiply better and become the predominant strain in the body. What is happening to the virus in the body is actually a basic law of nature. It is survival of the fittest at the level of the virus. At any one time, the cluster of different virus strains in a

single individual is about 5% different from each other. Strains from two unrelated individuals might vary by 35%.

VIRAL LOAD

Another concept gaining recognition is the importance of the "viral load." This refers to the amount of virus in the body. It's believed that individuals who do well have low viral loads and those who do less well have higher viral loads. This seems like a simple idea, but scientists are making progress in trying to measure a person's viral load. If the viral load can be measured successfully, one could predict when antiviral drugs are needed, or when it is time to change from one drug to another. ■

ODH seeks to reduce breast cancer

Can the number of Ohio women dying from breast cancer each year be reduced by the year 2000?

According to data from the Ohio Behavioral Risk Factor Surveillance System for '89-'90, 53% of Ohio women, 40 years and older, aren't meeting recommendations for mammography screening. Why? Their reasons:

- Their physician didn't recommend it (53%)
- They didn't know it was needed (31%)

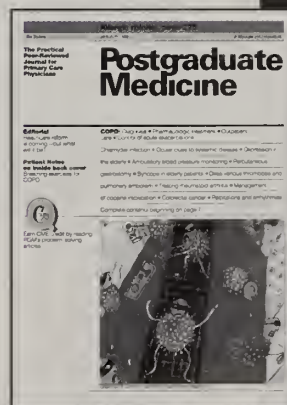
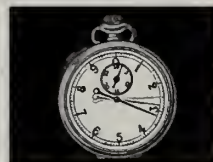
To help meet the Ohio Department of Health's objective of reducing the breast cancer mortality rate from 29.9 per 100,000 women (in 1987-1990) to 25.2 by

the year 2000, you should do the following :

- explain the components of breast cancer screening
- recommend mammography
- provide clinical exams at the appropriate age and intervals, notifying every woman of the results of her screening exams, and refer when necessary.

The passage of House Bill 142, which was approved by the Ohio Legislature last March, mandates that health insurance policies include benefits for mammography screening, so cost shouldn't be a factor with those with health insurance. ■

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Ohio worries about TB resurgence

Tuberculosis, which has made a strong comeback in such coastal cities as New York and Los Angeles, may soon be headed toward Ohio, and there is little

health officials can do to stop it.

Lack of money seems to be the primary reason for the state's vulnerability. Although Ohio receives about \$300,000 in federal

funds for tuberculosis, another \$600,000 is needed each year to help prevent general increases and outbreaks – and the money isn't available in this year's state budget.

About 500,000 Ohioans are believed to be infected with TB, and so far, new TB cases in the

state seem to be holding steady at 378. Frits van der Kuyp, MD, director of the Tuberculosis Clinic at Metro Health Medical Center in Cleveland, says that he has not yet seen a rise in patients at the clinic, but sees no reason why Ohio should be spared.

AIDS A FACTOR

"We may not see TB rise to the extent here that it has in New York," he says – a fact he attributes to Ohio's better outpatient

The "newest" drug to treat tuberculosis is more than 20 years old.

care. Still, such factors as homelessness and AIDS are increasing the number of tuberculosis cases across the country and could push up the numbers here as well.

Along with the increase in cases comes another scare – the appearance of a drug-resistant tuberculosis strain. Fortunately, only six cases of this strain have been reported in Ohio, and Dr. van der Kuyp confirms that he has seen few such cases at his clinic.

NEW DRUGS

Tuberculosis greatest tragedy, however, is that it is a preventable disease, yet despite this, the old-fashioned disease is making a comeback.

"The newest drug to treat tuberculosis is more than 20 years old," says Dr. van der Kuyp. TB's comeback is bringing a flurry of new and promising drugs to test sites across the country – including to MetroHealth's tuberculosis clinic. Ultimately, however, the answer to an approaching TB crisis in the state is prevention.

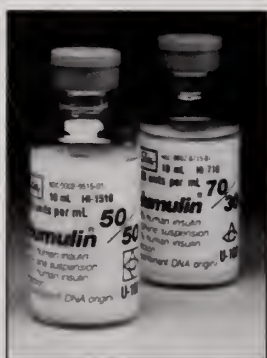
"TB has become a forgotten disease," says Dr. van der Kuyp. "Now we just hope enough publicity is given to this new increase that the medical community can move swiftly to prepare for it." ■



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MEIR GROSS, MD, Cleveland, The Hebrew University Hadasah Medical School, Jerusalem, Israel, 1963; age 56; died November 10, 1992; member OSMA.

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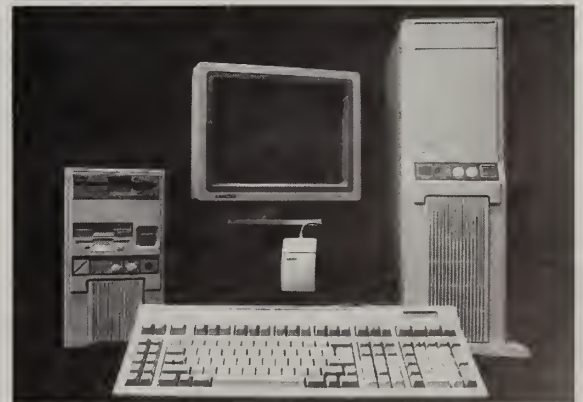
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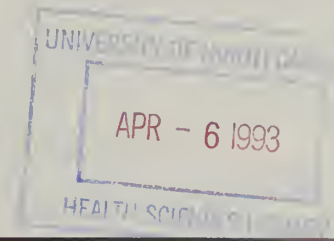
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News for Members of the Ohio State Medical Association

Vermont governor/MD key speaker OSMA holds Leadership Day

In Brief: Physician leaders meet to discuss health-care reform.

No matter how hard bureaucrats, businesses and politicians may try, it is going to be impossible to design a workable health-care reform system without input from that system's chief providers – the physicians.

That was one of the messages Vermont Gov. Howard B. Dean, MD relayed during his speech to county and specialty society officers at OSMA's Leadership Conference, held last month in Columbus.

Dr. Dean didn't hesitate to tell those in attendance that change is coming, saying that the nation's middle class has driven the government to seek ways to implement universal access to health-care in this country.

"As I see it, there are three criteria for health-care reform," says Gov. Dean. "Universal access and



OSMA President Stanley J. Lucas, MD, right, greets Vermont Gov. Howard B. Dean, MD who spoke at the OSMA's recent Leadership Day.

cost-control. Those two must be linked together. The third criteria is that the system has to be administered by the states." He pointed to Medicare as a perfect example of why the federal

government should not run a national health-care system, and went on to chide the CLIA regulations as the "price American

See **Leadership** page 2

Claire Wolfe named to Ohio health board

Claire V. Wolfe, MD, Columbus, has been appointed by Gov. George Voinovich to the 16-member Ohio Health-Care Board. Her appointment assures OSMA representation on the new policymaking entity that was created under House Bill 478, the health-care reform legislation passed

last year.

Dr. Wolfe currently serves as the 10th District Councilor to the OSMA and is running unopposed for the position of OSMA president-elect. (See related story on page 9.)

Dr. Wolfe is filling one of two board positions set aside for health-care providers. H. William Porterfield, MD, Columbus, a former 10th District Councilor to



Dr. Wolfe

See **Dr. Wolfe** page 2

Child abuse campaign kicks off

In Brief: OSMA begins the second part of its three-part campaign on family violence with information for physicians on child physical/sexual abuse.

By mid-April, more than 3,000 OSMA members will receive an educational packet on child abuse produced by the OSMA. The kickoff of the Ohio Physicians' Child Abuse Prevention Project is part of a three-prong approach to family violence being sponsored by the OSMA. A successful domestic violence campaign was launched last October, and an

See **Child Abuse** page 2

Inside

■ **NEW HEALTH BILLS:** A look at a few of the new health-care bills introduced at the Statehouse this year, and the OSMA's position on each. **3**

■ **PRESIDENT-ELECT CANDIDATE:** For the first time, the OSMA has a woman candidate, Claire V. Wolfe, MD running for the position of OSMA president-elect. **9**

■ **STATEWIDE FEES:** HCFA continues to play a "wait-and-see" game with OSMA's request for a statewide Medicare fee schedule. **22**



Dr. David Jackson

■ **FEDERAL REFORM:** An interview with David Jackson, MD, former state health director and newest member of Hillary Rodham Clinton's task force on health-care reform. **24**

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Leadership...*From page 1*

patients must pay" as the result of bureaucratic egos and inefficiencies.

VERMONT REFORM

Gov. Dean's own state is operating under a progressive health-reform bill that passed the Vermont Legislature a year ago this month and may serve as a reform model for the rest of the nation. In brief, the reform measure:

- created a Health Care Authority, charged with developing a health-care spending budget for the state, starting in 1994;
- required community rating for health insurance;
- tackled malpractice reform by mandating that every medical claim go first to arbitration, and making the findings of the panel admissible in court proceedings;

- expanded Medicaid to cover children under 18 whose parents fit into a certain income level.

How much, if any, of the Vermont plan will be plugged into an administrative health-reform proposal is still open to question. However, Gov. Dean is one of four governors who meets regularly with the key players on the Hillary Rodham Clinton Health-Care Task Force.

"I've told the task force that they have to listen to those who deliver care," says Gov. Dean.

ALL MUST SACRIFICE

He recognizes that physicians will have to make some sacrifices in the future.

"Physicians will have to give some; lawyers, hospitals, drug companies and insurance companies will all have to give some.



Nancy W. Dickey, MD, Richmond, Texas, a member of the AMA Board of Trustees, addresses Leadership Day participants.

Our trade-offs may be less bureaucracy and malpractice reform. But there is one group that will have to give the most of all, and this group is not even being discussed – the patient."

Physicians will have to con-

tinue to be their patients' advocates, Dr. Dean advises. That's why physicians must have a role at the bargaining table – so patients, as well as physicians, can be heard. ■

PICO loss reported at \$6.3 million

The Physicians Insurance Company of Ohio has filed a document with the Ohio Department of Insurance, reporting a \$6.3 million loss on a statutory basis for the 1992 calendar year.

Statutory accounting is used by state regulators to help determine an insurer's solvency and usually results in a report of lower earnings than if calculated using generally accepted accounting principles (GAAP), the type most often used in reports to shareholders, etc.

Early last month, PICO had indicated that it would reduce its 1992 earnings and its surplus by \$6.8 million in order to increase its reserves by the same amount.

The ODI will be reviewing all of PICO's financial reports as part of its regular overview of any insurance company's activities.

OHIO Medicine will keep you informed of any new developments. ■

Child Abuse...*From page 1*

elder abuse campaign is planned for the fall.

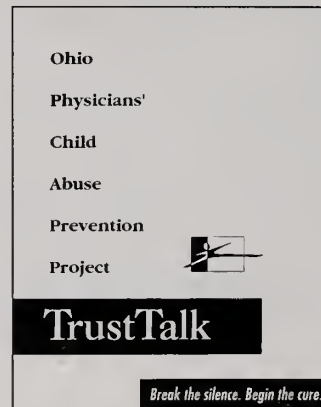
This mailing will educate Ohio physicians about child physical/sexual abuse and provide them with guidelines to follow when reporting child abuse cases, which is required by law.

According to OSMA President Stanley J. Lucas, MD, "Last year alone, the Ohio Department of Human Services received nearly 90,000 reports of child abuse and neglect. Only 7% of these reports came from medical professionals. We must do a better job of recognizing and reporting child abuse."

The educational handbook includes clinical guidelines, legal considerations and a list of county agencies to which physicians should report child abuse. Handbooks are being mailed directly to OSMA members in the following specialties: family and general practice, pediatrics and emergency medicine. All other OSMA members may order a handbook free of charge by using the order form elsewhere in this issue.

OMERF FUNDED PROGRAM

The child abuse campaign was funded through a \$13,000 grant



from the Ohio Medical Education and Research Foundation (OMERF). This foundation, which is affiliated with the OSMA, specializes in funding physician and public education programs. It is chaired by Oscar Clarke, MD, Gallipolis.

Physicians may earn two hours of Category I continuing medical education credit by reviewing the handbook and taking a test, which is enclosed in the packet.

The OSMA's child physical/sexual abuse campaign was developed with the assistance of the Ohio Chapter, American Academy of Pediatrics' Committee on Child Abuse and Neglect; the American Medical Association and many Ohio child abuse agencies.

The OSMA will be developing a speakers' kit on this issue. ■

Dr. Wolfe...*From page 1*

the OSMA, has also been appointed to the board to represent HMOs.

Jackie Fullerton, the former president and CEO of the Ohio Health-Care Coalition, will serve as executive director of the new health-care board.

"The Legislature has given us broad authority and our mission is very broad," she says. Fullerton expects the board to coordinate and implement true health-care reform in Ohio, and intends to use input from legislators, providers, employers and insurers in formulating reform measures.

"I'm not certain yet how we'll proceed, but I imagine we will work in a similar manner to the health-care task force in Washington," Fullerton says. That means smaller committees will be formed to look at the issues.

The board intends to start work immediately, and the first meeting of the group should take place early this month. The board will present an informational report on its progress to legislators at the end of the year, but, Fullerton says, "We won't wait until the end of the year to implement changes." ■

Health-Care Legislation for 1993

Bills affecting health-care continue to be introduced in the Ohio Legislature. The OSMA carefully monitors all such bills and, when appropriate, the association's Committee on State Legislation, chaired by John Verhoff, MD, Columbus, takes a position – either of support or opposition, or, in some cases, no position at all.

Listed below are the newest health-care bills under consideration by state legislators, and OSMA's position on each.

House Bill 18 – Assisted Suicide

Sponsor:
Dale Van Vyven (R-Sharonville)

Content:
Establishes felony criminal penalties for anyone who assists or attempts to assist another person in the commission of suicide.

Comments: The OSMA has policy against active, voluntary euthanasia. Last month, two OSMA members, Mary Jo Welker, MD and Warren L. Wheeler, MD testified in support of the bill, which would make assisted suicide a felony in this state.

Concerns: While the OSMA is committed to the principle of opposing assisted suicide, it is concerned with overly broad legislation that might impede the appropriate practice of medicine.

Status: At press time, there have been two hearings on this bill held by the House Judiciary Committee.

Senate Bill 7 – Assisted Suicide

Sponsor:
Grace Drake (R-Solon)

Content:
Similar to HB 18, above.

Status: At press time, there had been no hearings on this bill.

Senate Bill 9 – Assisted Suicide

Sponsor:
Betty Montgomery (R-Perrysburg)

Content:
Similar to HB 18, but more narrowly drawn.

Status: At press time, there had been no hearings on this bill.

Senate Bill 22 – Tanning Parlors

Sponsor:
Charles Horn (R-Dayton)

Content:
Requires periodic testing of sun lamps in tanning parlors by the operators and replacement of bulbs when they decline to 70% of their original irradiance level.

Comments: OSMA has policy in support of this legislation.

Concerns: For legislators, the chief concern is the cost and reliability of the dosimeters that will be used by the state in testing the lamps during inspections.

Status: Two hearings have been held on this bill, in the Senate Health and Human Services Committee as of press time.

Senate Bill 29 – Corporal Punishment

Sponsor:
Dick Schafrath (R-Loudonville)

Content:
Prohibits the use of corporal punishment in public schools that don't expressly permit its use.

Comments: Since 1983, the OSMA has consistently supported legislation banning corporal punishment, and currently has policy opposing corporal punishment. Last month, Charles Reiner, MD, representing both the OSMA and the American Academy of Pediatrics testified before the Senate Education, Retirement and Aging Committee in support of Senate Bill 29.

Status: At press time the bill remains in the Senate Education Committee.

House Bill 11 – Execution by Lethal Injection

Sponsor: Ronald Mottle (D-Parma)

Content: Permits capital punishment to be administered by lethal injection.

Comments: The AMA's ethical guidelines oppose the concept of physicians administering lethal injections. These guidelines also say any physician participation in executions is unethical.

Concerns: The bill is presently silent on the matter of who will administer lethal injections if the legislation is enacted. In some states, nurses have been called in to administer lethal injections in state executions. So far, House Bill 11 only stipulates that the warden will arrange for the lethal injection to take place. Ohio is one of at least 20 states that require a physician to pronounce death, which may place them in jeopardy with AMA guidelines on this issue. The physician need not be present, however. He or she can rely on the report of "competent observers." (See related story on page 14.)

Status: At press time, the bill is awaiting a vote by the full House.

Medical Board proposes raising license fees

In Brief: The Ohio State Medical Board is asking the Ohio Legislature to raise license fees for physicians from \$160 to \$300. They also propose that the money go into a special fund, for use by the board, and not into the state's general fund.

The Ohio State Medical Board (OSMB) has recently submitted a request to increase physician licensure fees nearly 100% – from \$160 per biennium to \$300. The request was made to a subcommittee in the Ohio House, which the board hopes will make their request part of the state's biennial budget.

Instead of this money going into a general fund, as it has in the past, however, the legislation calls for the money to be placed in "Special Fund 21" (so called because funds would come from 21 of the state's regulatory boards).

MONEY WOULD FUND SEVERAL PROJECTS

The increased fees will be used by the medical board to implement a number of projects it has proposed, including early intervention in minimal standards cases; creation of a prescription drug diversion unit; compliance monitoring; improving access to public information; and increasing staff. Increased fees will also help the board pay for its new mandate, established by House Bill 478, which calls on the board to create a unit dedicated to overseeing the financial relationships between laboratories and physicians.

Two years ago, license fees for physicians were raised from \$100 to \$160 per biennium. The proposed increase to \$300 would become effective in 1994.

LEGISLATIVE APPROVAL NEEDED

"One thing to remember," says John Van Doorn, director of OSMA's Department of Legisla-

tion, "is that there is no guarantee that, even if this legislation passes and the license fees are deposited into a special fund, the governor and the Legislature won't take money out of this fund to use for different purposes."

The state medical board will also need to obtain legislative approval for any money it proposes to remove from the fund to pay for any additional projects.

Physicians' fees won't be the only fees raised, either. License fees for physicians' assistants could increase from \$5 to \$50 annually, and limited branch practitioners (such as cosmetic therapists) will rise from \$25 to \$100 for their biennium.

OSMA WILL REVIEW PROPOSAL

The OSMA and the association's Ohio State Medical Board Task Force, chaired by OSMA President Stanley Lucas, MD, intend to review the OSMB proposal carefully.

"In the past, we have indicated to the board that we would support a moderate fee increase if the money raised would go directly to the board to help fund certain programs that benefit physicians," says Dr. Lucas. "We are

concerned, now, however, about the amount of increase being proposed and how that money would be spent."

The fact that almost a 100% increase has been proposed without a guarantee that the board will have free access to the money has made the OSMA regard this newest license fee increase with some caution. The association is also uncertain as to whether all of the programs the board proposes to fund with the increase are necessary.

"Before we can evaluate these proposed programs, we need additional information from the board," says Dr. Lucas. "And we certainly invite comments from both the board and our members on this matter."

For now, however, the OSMA has expressed its reservations to the House Finance subcommittee that is holding hearings on the proposed increase.

If you wish to comment on this issue, please address your letters to the Executive Editor, *OHIO Medicine*, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

Of course, *OHIO Medicine* will keep you posted on the outcome of this proposal. ■

Rep. Sweeney to be OMPAC speaker

State Rep. Patrick A. Sweeney (D-Cleveland), now in his second term as chair of the House Finance and Appropriations Committee, will be the featured speaker at the OMPAC dinner, to be held May 15 at the Stouffer Tower City Plaza Hotel in Cleveland. The dinner will be held during the OSMA's Annual Meeting.

Elected to the House of Representatives in 1966, Rep. Sweeney is presently in his 14th consecutive, two-year term as state representative. In addition to his post with the House Finance Committee, Rep. Sweeney is also a member of the Health and Retirement Committee, the House Ethics and Standards Committee and the House Financial Institutions Committee, among

others.

Although the topic of his speech was unknown at press time, his key issues of legislative interest have been education, health-care legislation and Medicaid reform, as well as budget issues and arts legislation.

A special reception will be held for members of OMPAC's 300 Club prior to the OMPAC dinner. The reception will begin at 7 p.m., and members will have a chance to meet and talk with Rep. Sweeney before adjourning to dinner at 7:45 p.m.

Anyone wishing to attend this event should fill in the registration form elsewhere in this issue or contact the Department of Legislation at 1-(800) 766-OSMA for more information. ■



Physicians Testify on Medicaid

Testifying before legislative committees is a time-consuming business, but three primary care physicians recently took time from their practices to travel to Columbus to address members of the House Finance and Appropriations Committee on a proposal to raise Medicaid reimbursements to physicians. From left are: Roger D. Jenkins, MD, Lima; Ted Wymyslo, MD, Dayton; and Richard H. Tuck, MD, Zanesville.

Health task force will hold first meeting

OSMA's task force on health-care reform, appointed by OSMA President Stanley Lucas, MD and featured in last month's issue, is up and running and will hold its first meeting early this month.

The task force, chaired by President-Elect Walter A. Reiling, Jr., MD, Dayton, has been charged with the task of producing an Ohio physicians' health-care reform plan that will serve as the foundation of OSMA advocacy in the future.

Task force members hope to meet once or twice a month until they develop a workable plan to take to the state Legislature.

Members of this new task force are as follows:

Walter A. Reiling, MD – Chair, Dayton

Mark Bechtel, MD, Columbus

Thomas Fenzl, MD, Wooster

Robert K. Finley, Jr., MD, Dayton

Jack Fitzgerald, MD, Concord

David D. Goldberg, DO, Dayton

Daniel Handel, MD, Youngstown

Morton L. Harshmann, MD Cincinnati

William L. Hassler, MD, Elyria

Charles Hickey, MD, Columbus

Susan L. Hubbell, MD, Lima

Eleanor Johnson, Columbus

Samuel J. Kiehl, MD, Grove City

Unni Kumar, MD, Cleveland

L. Edgar Lee, MD, Columbus

S. Christopher Lee, MD, Columbus

Teresa Long, MD, Columbus

Patrick H. Macedonia, MD Steubenville

Paul McEnery, MD, Cincinnati

W. Jeanne McKibben, MD, Oberlin

J. Robert Navarre, MD, Toledo

Peter J. Plantes, MD, Cleveland

Robert E. Schulz, MD, Wooster

Ronna Staley, MD, Copley

Robert E. Stegemiller, MD, Middletown

Mary Alice Streeter, Wooster

Mary Jo Welker, MD, Columbus ■

Bill would mandate treatment of Medicaid patients

In Brief: If passed, HB 183 would require physicians to treat their "fair share" of Medicaid patients and set up primary care physicians as gatekeepers of the health-care system.

If passed, a new Medicaid reform bill, recently introduced by Rep. Paul Jones (D-Ravenna) and Rep. Michael Fox (R-Hamilton), would mandate physicians to treat their "fair share" of Medicaid patients.

According to House Bill 183, "fair share" would be determined by guidelines written by the Ohio

association is strongly opposed to any mandate that compels physicians to treat Medicaid patients.

"While physicians may feel an ethical obligation to treat Medi-

caid patients, their license to practice medicine should not hinge on whether or not they choose to do so," says Van Doorn. "It's unjust to put their licenses in

jeopardy this way."

He urges physicians to send letters now to their state representatives, expressing opposition to the Medicaid mandate in HB 183. Letters should be sent to: The Ohio House of Representatives, 77 S. High Street, Riffe Center, Columbus, OH 43266-0603. ■

The OSMA is opposed to any legislation that compels doctors to treat Medicaid patients.

Department of Health, in consultation with the Ohio State Medical Association.

In addition, the legislation would:

- Require that Medicaid establish a statewide primary care/case management system that would make primary care physicians responsible for the coordination of any health care needed by the Medicaid recipient. The bill also urges Medicaid to contract with private sector, managed-care plans if possible.
- Consolidate all public health programs to Medicaid recipients, creating a new state agency – the Ohio Agency for Health Services.

LETTERS NEEDED

The bill was just introduced at press time, so the OSMA is still in the process of reviewing it, but the OSMA's Legislative Director John Van Doorn says that the

[A large, dense block of handwritten signatures, mostly in cursive, covering the left side of the advertisement.]

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PRESIDENT'S PERSPECTIVES

IMGs: An integral part of medicine

During the past few years I have had the opportunity to participate in several International Medical Graduate-sponsored programs.

It has always been an enlightening experience to better know these dedicated physicians and their concerns. I can assure you, they do not suffer from apathy. The IMGs uniformly seem to be involved and knowledgeable about the health-care problems that all of us in medicine face. In addition, of course, they have concerns about the discrimination they encountered while working toward their career goals. They are sincerely interested in the removal of these barriers as they relate to the young physicians from their native countries who are embarking on this medical journey.

The IMGs are an integral part of medicine and supply a significant amount of the health care of our nation as primary-care physicians, specialists and residents in

training. It is important for organized medicine and educators to sharpen our awareness of the significance the IMG physician plays in the health-care system.

The numbers speak for themselves. In Ohio, IMGs number

other states have developed IMG task forces.

The OSMA last year was instrumental in having HB 454 passed in Ohio, and the AMA was helpful in securing passage of the Solarz Kennedy bill in

barriers. The IMGs, on the other hand, know that leadership positions will be achieved by hard work, dedication and increasing identification with organized medicine. Those IMGs who reach high levels of responsibility will not only bring honor to themselves but will also reflect the accomplishments of the entire IMG group.

Organized medicine needs the IMGs and the IMGs need organized medicine. We must continue to build bridges and remain unified as we approach the knotty problems of medicine's future in the 1990s and into the 21st century. ■



Stanley J. Lucas, MD

Task forces are doing much to eliminate the barriers faced by IMGs.

approximately 6,600 or 30% of the licensed physicians. Less than 50% of the licensed IMGs (3,000) are members of the Ohio State Medical Association.

The IMG has felt discrimination over the years from education and residency programs, state licensing, medical organizations and from their fellow American graduates. Changes are occurring in the elimination of these barriers. Task forces being activated in Ohio as well as at the AMA will seek relief for the IMG. Thirteen

Congress; both pieces of legislation assist IMGs in licensing problems.

On March 10th and 11th, the 4th Annual IMG Forum was held in Washington D.C. where key IMG and AMA leaders – including the OSMA's own Dr. Su-Pa Kang, a representative of the AMA National Advisory Council, and Dr. Woong Suh Kim, chair of the OSMA IMG Task Force, met and discussed important issues.

Organized medicine realizes its responsibility to help lower the

OHIO Medicine

News for Members of the Ohio State Medical Association

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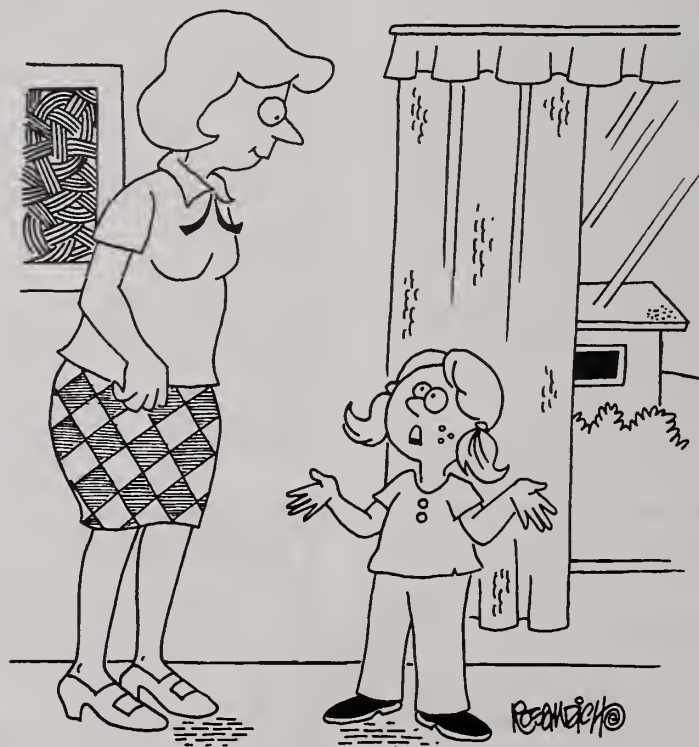
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"Of course I wouldn't play doctor with Donald, Mother. He doesn't have malpractice insurance."

AUXILIARY REPORT

Auxilians celebrate accomplishments

This is the time of year the auxiliary is busily preparing for its Annual Meeting to be held in Cleveland May 13-14. The convention gives us the opportunity to celebrate the accomplishments of the previous year and accept the challenges of the year to come. Ohio's auxiliaries have much to celebrate and Ohio's auxiliaries have many challenges ahead.

When OSMA asked the auxiliary to work with them on their domestic violence initiative, we accepted the challenge. Auxiliaries across the state attended two focus meetings and became educated about the problems and learned how they could help. Most county auxiliaries in this state have done something to address the problem, and we celebrate those efforts. From county auxiliary informational meetings, town meetings, a 30-second informational commercial on family violence, major fund-raising efforts for local battered women's shelters, to distributing

informational leaflets, auxiliaries have been there. Plans are under way in many counties to expand this focus to child and elder abuse.

Combating domestic violence was just one challenge the auxiliary accepted.

Auxiliaries across Ohio have once again set the pace for raising funds for AMA-ERF. Presentations of AMA-ERF checks to the deans of Ohio's medical schools will take place at the convention. The message brought by the deans strengthens the need for our continued efforts in helping support medical education. Counties are participating in a large "theme basket auction" at convention to raise additional funds for ERF. Delegates to the OSMA meetings are encouraged to visit the auxiliary hospitality room to place bids on these theme baskets. Additionally,

the famous Ohio rhinestone pins will be on sale. All profits on the sale of these pins goes to AMA-ERF.

Along with the bylaws changes

that are proposed for consideration, deliberations will be focused on the proposed resolution on changing the name of the OSMA Auxiliary to Alliance, with the tagline, "Physicians' spouses dedicated to the health of America." Delegates to convention will be voting on this issue following a planned reference committee meeting. The change of the organization's name to Alliance marks an effort to better reflect the lifestyle of today's physicians' spouses. The new name reflects the increasing diversity of our membership.

Highlighting our convention

will be AMA-Alliance President-Elect Mary Hanson of Colorado. She will speak at the first session of the House of Delegates.

The site of the Annual Meeting is the Stouffer Tower Center Plaza, Cleveland.

Leadership Day precedes the convention on May 12 with speaker Dadie Perlov addressing the future leadership of Ohio's auxiliaries on "Coping in Today's Environment." Perlov will also conduct mini-workshops with county membership chairs.

Come to Cleveland May 12-14 and celebrate with the auxiliary and accept the challenges that await all the spouses of physicians. ■



Sara Rich, President

LETTERS TO THE EDITOR

Toledo hospitals exonerated

To the Editor:

I write in behalf of Toledo area hospitals and physicians to protest the statement prominently printed in red on page 13 of the February *OHIO Medicine*: "A Toledo-area hospital denied treatment to an AIDS patient."

In fact, the exact opposite is true. The patient was transferred from a Fremont hospital to the Medical College of Ohio Hospital here in Toledo. These facts are correctly reported in the first and last paragraphs of your article. Yet your red type causes headline readers to jump to the erroneous conclusion that Toledo turned this patient away.

We would appreciate a correction in your next issue. Thanks for your attention to this matter.

JOHN H. ROBINSON, MD
Toledo

Editor's Note: *OHIO Medicine regrets the error and apologizes for any misconceptions about Toledo hospitals and/or physicians. (See related story on page 14.)*

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SECOND OPINION

"Fixing" health care for the year 2000

By Samuel A. Nigro, MD

The current health-care system is broken and a simple "fix" is no longer enough. A new way of thinking is what will be needed for the third millenium. For example:

PRINCIPLE #1

Health-care dollars must be used for health care.

Dollars should not be wasted on "administrative costs." The federal government, in conjunc-

tion with the medical profession, must be the first to use the new electronic billing system – by-

Physicians should be in medicine to provide a service to people, not to exploit a business.

passing all paperwork for claims processing. The government should place in each physician's office a computer terminal into

which would be entered the patient's health-care identifying data, the medical procedure

provided, and the costs. Once entered, this would automatically transfer the appropriate amount of dollars directly into the physician's account. No paperwork. No costs for processing bills and checks.

PRINCIPLE #2

Physicians' incomes should be capped.

Physicians should be in medicine to provide a service to people, not to exploit a business. To be a physician, one should be willing to accept a ceiling on income as proof that he or she wishes to care for the ill more than anything else, including big-business venturing.

PRINCIPLE #3

Physicians' licenses should be dependent not only on Continuing Medical Education (CME), but also Continuing Patient Care (CPC).

In order to renew a medical license, a minimum of 1,000 CPC hours per X number of years, for example, would have to be documented. This would force health-care practitioners into providing health care rather than taking administrative jobs that diminish the total health-care system.

Space doesn't allow elaboration on major medical catastrophic costs, standard health-care allowances, health-care dollar collections and health-care dollar disbursement programs, but

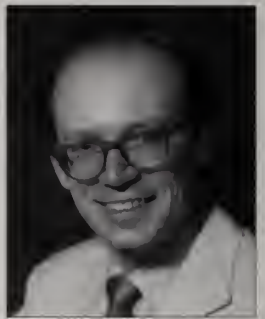
these would all be attended to and supportive of the Federal Medical Reserve Fund.

The Federal Medical Reserve Fund is the overriding principle necessary for the working of this new system. All monies paid

into any health agency for providing services would go into this fund. Accumulated dollars would be invested in the safest manner, and 100% would be reinvested to increase health-care dollars available, and not taken as profits by the private health-care insurance companies, as is now the case. No dollars would be removed from this fund, except for health-care payments. This fund would be legislatively immune to attachments by any form of litigation, and would thus be the source of capital for private enterprise.

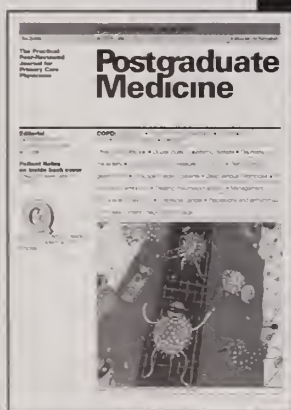
The approach outlined above will re-establish individual medical care, based upon the physician-patient relationship, and with a clear commitment of physicians to their profession. Even more important, these physicians would be paid adequately by a system that is itself maintained by physician involvement. ■

Samuel A. Nigro, MD, practices psychiatry in Mayfield Heights.



Dr. Nigro

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Postgraduate Medicine

Claire Wolfe, MD, is first woman candidate for OSMA president-elect

A belief in organized medicine drove Claire V. Wolfe, MD, Columbus, to run for OSMA president-elect. Dr.

Wolfe is running unopposed for the office. She will formally be elected to the position next month at the

association's Annual Meeting in Cleveland.

"I believe in and have participated in organized medicine for many years," she says. "The challenges are so incredible. I know how to deal with challenges and believe I have the strength to give to my fellow physicians. Most physicians who know me, trust me. They trust I will do well for both them and for their patients," she says.

Being the first woman to hold the office of president-elect for the organization is not an issue according to Dr. Wolfe. "I've been totally obtuse my whole life," she says. "I never perceived being a woman as a problem and I can't recall ever being discriminated against," she says. "In fact, it was my male mentors who pushed me in most of my career moves," she says.

MEDICAL BACKGROUND

Dr. Wolfe graduated from the Ohio State University College of Medicine in 1968, and served her internship at Los Angeles County-USC Medical Center in Los Angeles, California. Her residency was done in physical medicine and rehabilitation at the Ohio State University Hospitals. In 1974, she was certified by the American Board of Physical Medicine and Rehabilitation, and in 1989, by the American Board of Electrodiagnostic Medicine.

She has served in various posi-



Dr. Wolfe

tions in the OSMA, including: District 10 Councilor; chair of the OSMA-Ohio Nurses Association; and a member of several committees, including Long-Range Planning, Auditing and Appropriations, and Workers' Compensation. She has been a delegate to the American Medical Association from Ohio, served on the Board of Trustees for Peer Review Systems, Inc., Physicians Health Plan and the Educational Foundation of the Academy of Medicine of Columbus and Franklin County.

Ask her what specific qualities she brings to the position and Dr. Wolfe will tell you she's been involved in every level of organized medicine. "I've been on practically every committee. I've seen the hospital side, the business side, the ethical side. I bring a broad span of experience to the job," she says.

DR. WOLFE SETS GOALS

Dr. Wolfe has set the following goals:

- "To foster a greater unity among our members. Get them out of their depression. Make them feel proud to be a doctor again."
- "Improve our image with the public. Let the public know that we care about them and are not interested only in the almighty dollar."
- "Try to get through health-care reform in a positive way. It will be difficult. We are dealing with a broad base of older physicians who feel paranoid about what's going on, about losing their autonomy and independence, and younger physicians who aren't nearly as threatened, many of whom are actively seeking salaried arrangements. The physician groups don't agree with each other, and both groups disagree with the government. We must appeal to all sides." ■



Annual Meeting Site

Don't forget this year's OSMA Annual Meeting May 14-17 at the Stouffer Tower City Plaza Hotel in downtown Cleveland. The activities kick off with the first session of the House of Delegates Friday evening, followed by the installation of Walter Reiling, Jr., MD as OSMA president. Reference committees convene early Saturday morning, with the final session on Sunday.

Resolutions for '93 Annual Meeting

Editor's Note: Many resolutions have been received, but we are required by the OSMA Constitution and Bylaws to publish those resolutions that affect the Constitution and Bylaws.

Ohio State Medical Association House of Delegates

Introduced by: OSMA Council

Subject: Davis' Rules of Order

WHEREAS, The OSMA Constitution and Bylaws currently states that the order of business of the OSMA House of Delegates shall be according to the Sturgis' Standard Code of Parliamentary Procedure; and

WHEREAS, At its 1992 Annual Meeting, the American Medical Association House of Delegates amended the AMA Constitution and Bylaws to state that the House of Delegates be governed by the parliamentary rules and usages contained in the current edition of Davis' Rules of Order, which was developed and written by James E. Davis, MD, former speaker of the AMA House of Delegates and past president of the AMA; and

WHEREAS, Davis' Rules of Order addresses the current usage of parliamentary procedure that preserves the essential and disregards the obsolete practices, and that seeks to present the basic material in the clearest, easiest understood, and most readily applicable manner, therefore be it

RESOLVED, That the OSMA Bylaws be amended as follows:

CHAPTER 4 HOUSE OF DELEGATES

Section 14, Order of Business. The order of business of the House of Delegates shall be according to Sturgis' Standard Code of Parliamentary Procedure DAVIS' RULES OF ORDER.

The order of business may be modified for any session by the presiding officer with consent of the House of Delegates. ■

OSMA In Action

A round-up of the association's activities...

Focus groups discuss group practices

A focus group involving administrators and physicians from large group practices (40+ physicians) from around the state was held in early March. The information will be used as a guide for discussion by the OSMA's Group Practice Advisory Committee.



Dr. Castele

AMA activities

Ted Castele, MD, Cleveland, chair of the Ohio Delegation to the AMA, asked for and was given Council's approval of the revised informational handbook that has been prepared describing the activities and duties of the delegation.

Young Physicians Committee sets goals

Members of the OSMA Young Physicians Committee are encouraging young physicians from around the state to get involved at all levels of organized medicine. At a recent meeting of the group it was pointed out that a significant number of young physicians are involved at the county level, but James M. Sudimack, MD, chair, would like to see even more involvement in the county societies, OSMA, and AMA. A letter is in the works to send to young physicians explaining how they can access the system and get involved. This committee would like to see an increase in the number of leadership positions in organized medicine for young physicians so that they have a significant voice.

Cancer checklists available

The OSMA Committee on Cancer has updated its cancer screening checklists. First created about five years ago, the lists are for the use of primary care physicians and are available for both male and female patients. The checklists, which are free, may be obtained by contacting Robert Clinger, OSMA's Department of Medical Society and Member Relations at 1-(800) 766-OSMA.



CME symposium big success

More than 130 physicians and hospital personnel gathered for the OSMA-sponsored Symposium on Continuing Medical Education in late February in Columbus. Representatives learned the required procedures prior to beginning the accreditation process.

Membership on the rise

OSMA's director of Membership, Doug Evans, reports that successful retention and recruitment programs have resulted in an increase in membership for the first time since 1989. As of March, 1993 OSMA total membership was at 14,025.

Mentor program in progress

The Young Physicians Committee has endorsed a mentor program with physicians and residents. The purpose of the program is to foster an interest in organized medicine. It will involve periodic informal meetings with a practicing physician where residents can discuss the issues facing medicine. Letters have been sent to residents and practicing physicians interested in mentoring. The OSMA staff will help coordinate the matching process. For more information, contact Dave Torrens, OSMA staff 1-(800) 766-OSMA. ■

Auxilians' activities mark Doctors' Day

In recognition of National Doctors' Day March 30, the OSMA Auxiliary honored physicians around the state in a number of ways.

Physicians representing different medical specialty societies were asked to write updates on their particular specialty in an effort to educate the public about the role doctors play in health care today. These articles were sent to local newspapers around the state asking them to print the materials in conjunction with Doctors' Day.

Other counties honored their physicians with a recognition dinner, proclamations, carnations, advertisements in the local paper or donations to the AMA-ERF.

Members of the Cleveland Academy Auxiliary sought donations from auxiliaries, friends and neighbors for four local domestic violence shelters in honor of their favorite physicians. As of this writing more than 50 donations had been received, with more than \$1,000 pledged. The names of the physicians in whose honor the checks were written were

listed in the March edition of *The Cleveland Physician*. This event incorporated Doctors' Day with the ongoing auxiliary campaign devoted to domestic violence.

An award will be presented at the auxiliary convention in May for the most unique Doctors' Day observance that had widespread impact on the community.

"All of this is a reminder to individuals to thank physicians for contributions to the health and well-being of our citizens," says Grace Martin, Doctors' Day chair. ■

Workers' Comp deadline nears

It's time again for physicians to decide whether or not to participate in OSMA's Workers' Compensation group rating program.

Last year Ohio physicians saved \$2.5 million in insurance premiums by joining the program.

Those physicians who participated in the second year of the program will realize a savings of 50% of their total annual premium.

To learn more about the plan, look for the insert elsewhere in this issue. ■

Colleagues

Ronald C. Agresta, MD, Steubenville, was elected president of the Ohio State Medical Board. Dr. Agresta is chief of staff at St. John Medical Center.



Dr. Agresta

Richard L. Banning, MD, Salem, was elected chief of staff of Salem Community Hospital.

Robert T. Brodell, MD, Warren, was installed president of the Trumbull County Medical Society. Dr. Brodell is an associate professor of internal medicine at Northeastern Ohio Universities College of Medicine where he heads the dermatology section.

C.M. Carandang, MD, Elyria, was elected president of the medical staff at Elyria Memorial Hospital.

Alan Cordell, MD, a Cincinnati urologist, was elected president of the medical-dental staff at St. Francis-St. George Hospital.

Richard Jay Farnham, MD, Alliance, was named director of occupational medicine for Alliance Community Hospital.

Helen Glueck, MD, a medical researcher for 41 years at the University of Cincinnati, received a Great Living Cincinnati Award from the Chamber of Commerce. Dr. Glueck continues her research at UC's Coagulation Laboratory, which she founded.

John S. Held, MD, Cincinnati, was named chief of staff for Mercy Hospital of Fairfield.

Stanley B. Ignatow, MD, Hamilton, was elected president of the Butler County Medical Society. Dr. Ignatow, director of radiology at Fort Hamilton-Hughes Memorial Hospital, is president-elect of the Ohio State Radiological Society.

Gary Lau, MD, Springfield, was elected president of the Clark County Medical Society.

Robert Maltz, MD, Amberly Village, was named director of the Department of Otolaryngology for Jewish Hospital.

Jerold Meyer, MD, Fresno, was elected chief of staff at Cochocton Memorial Hospital.

Henry W. Neale, MD, Mt. Lookout, was named president of The Association of Academic Chairmen in plastic surgery.

John C. Ouligian, MD, an anesthesiologist in Willoughby, was elected president of the Lake County Medical Society.

Leonard P. Rome, MD, Shaker Heights, received the 1992 Clifford G. Grulee Award from the American Academy of Pediatrics. ■



Dr. Rome



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CALENDAR

The OSMA has planned the following practice management workshops for 1993. Watch for more information on these workshops in future issues of *OHIO Medicine*.

Medical Office Management Institute (MOMI)

These workshops have been designed for medical office managers, supervisors and key employees. Some offices have used these workshops to upgrade the skills of established personnel as well as for indoctrination of new employees. The following five-day workshops can be taken in any combination:

- effective personnel management techniques;
- improving your managerial effectiveness;
- patient flow management;
- financial management;
- improving your third-party reimbursement and coding

June 28-July 2, Cleveland Stouffer Tower City Plaza, Cleveland
August 2-6, Cincinnati Kings Island Inn, Kings Island, Ohio

How to Run a More Profitable Practice

This one-day workshop is designed to show you the steps to a smarter, leaner and more profitable practice. Learn where your trouble spots are and how to bring them under control.

Sept. 28 Marriott Airport, Cleveland
Sept. 29 Concourse Hotel, Columbus
Sept. 30 Marriott, Cincinnati

Maximizing Your Collection Results

This one-day course is designed for the experienced office manager, billing supervisor and physician manager. The course deals with all aspects of the collection process. Learn to identify the problem, correct it and make certain it doesn't return. The workshop approaches the collections function from the management perspective.

Oct. 12 Dana Center at MCO/Hilton, Toledo
Oct. 13 Sheraton City Center, Cleveland
Oct. 14 Parke Hotel, Canton
Oct. 26 Concourse Hotel, Columbus
Oct. 27 Stouffers, Dayton
Oct. 28 Sheraton, Springdale, Cincinnati

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Fractured Phrases

Editor's Note: OSMA Senior Director Herb Gillen has spent a lot of time in meetings through the years. To help pass the time, he began collecting "fractured phrases" – advice, homilies, homespun phrases and the like – that stood out from the regular, dry meeting fare. From time to time, *OHIO Medicine* will publish a selection of these fractured phrases, so fair warning to all those who attend a meeting with our senior director present: The words you utter there may very well end up here.

PHRASES THAT COMPARE...

- That's like ice cream staying hard in July.
- That's like a chicken laying duck eggs.
- That's like dancing with a bear – the bear decides when to stop.
- That's like watching a peep show with one eye closed.
- That's like using the bathroom – you're not done until you do the paperwork.
- That's like killing the horse before it gets off the ground.
- That's like being the only tree in a dog kennel.
- That's like sitting in Vietnam with a BB gun.
- That's like elephants stampeding a couple of mice.
- It's like swimming in a pool full of jaws.
- That's like bringing flowers home to your wife for no good reason.
- This is like having a small hose against a big fire.
- That's like stepping on a bar of soap in the dark.
- That's like trying to catch a gorilla with a butterfly net.
- It's like the mouse stealing the cheese when the cat is out chasing someone else.
- That's like taking a drink from a fire hose.
- That's like a wee tree in a forest.
- That's like asking pigeons to clean the statues. ■

Workshop teaches physicians how to communicate with patients

Do your patients say that you don't listen to them? Do they complain that you don't explain things adequately? If you answered yes to either of these questions, you may want to plan to attend the upcoming "Physician-Patient Communications" workshop April 17 at Sawmill Resort in Huron.

The half-day workshop, sponsored by the OSMA Committee on Education, will teach participants to improve their communication skills through lecture, videotaped simulations, demonstrations and clinical role-playing. Jerry L. Hammon, MD, an

independent consultant to hospitals for medical staff programs, will facilitate the workshop.

Physicians who complete the workshop should notice a marked improvement in their relationships with their patients, and increased patient adherence with therapeutic regimens.

Physicians may also decrease their chances of being sued, as 60% of the malpractice claims filed in the United States are due, in part, to problems with physician-patient communication.

For more information, contact Janet Orbaker, OSMA CME Coordinator, 1-(800) 766-OSMA. ■

Health reform tops HMSS agenda

The future of health care will be the topic of the OSMA-HMSS Annual Assembly on May 14 at Cleveland's Stouffer Tower City Plaza Hotel. The meeting will begin at 9 a.m. and adjourn at 12:30 p.m.



Rep. Jones

John B. Crosby, senior vice president of the American Medical Association's Department of Health Policy Development, will elaborate on federal health-care reform and anticipated legislation, while Rep. Wayne Jones (D-Akron) will focus on state health-care reforms. A panel discussion, moderated by John Van Doorn, director of the OSMA Department of Legislation, will follow.

A look at the American Hospital Association's initiatives will be presented by John E. Callender, senior vice president of the Ohio Hospital Association.

Lance A. Talmage, MD, OSMA-HMSS chair, will tackle the subject of physician negotiations and advocacy programs. Oscar W. Clarke, MD, vice chair of the AMA Council on Ethical and Judicial Affairs, will present the

council's views on conflict of interest regarding self-referral and examine the controversial issue of physician-assisted suicides. Another panel discussion

will follow.

A short business meeting will be conducted prior to the presentations. Resolutions to be submitted to the OSMA-HMSS House of Delegates will be discussed.

Hospitals are encouraged to send physicians or other inter-

ested individuals to the meeting. For more information, contact Shar Wackman, OSMA Department of Development and Member Services, at 1-(800) 766-OSMA. ■



Dr. Talmage

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Hospital denies AIDS discrimination

A Fremont hospital has responded to a lawsuit brought by an AIDS patient alleging discrimination.

Last November, the American Civil Liberties Union filed suit on behalf of Fred Charon, who claimed he was refused treatment at Memorial Hospital because he has AIDS. Charon's suit alleges the hospital violated the Americans With Disabilities Act, a first for Ohio.

A doctor denies saying, "If you get an AIDS patient in the hospital, you'll never get him out."

In its answer to the suit, however, the hospital denies wrongdoing and has asked for a jury trial, should the case get that far. At press time, the case was in discovery, when both sides are given time to gather evidence to support its claims.

Charon alleges he was discriminated against last April when he became ill while driving through Ohio and sought treatment at Memorial. Charon was examined in the emergency room, but was transferred to the Medical College of Ohio, which he claims made his condition worse.

The hospital denies that the physician who denied Charon's admission violated the emergency transfer requirements of the Emergency Medical Treatment and Active Labor Act of 1986. It also denies that one physician said to another, "If you get an AIDS patient in the hospital, you'll never get him out."

Charon is reportedly dying in a Portland, Maine hospital. If he does die, attorneys will ask the court that the case be dismissed. (See related Letter to the Editor on page 7.) ■

Legal Notes

In Brief: This column is condensed from the OSMA's legal fact sheet notebook. You may want to cut and save this column for reference. Questions should be referred to the OSMA's Department of Legal Services.

Certification of Death

Only physicians can pronounce death.

Under Ohio Administrative Code Rule 4731-14-01, only a licensed medical or osteopathic physician can pronounce a person dead.

A physician doesn't have to personally examine the deceased's body, but may rely on the medical facts recited by a "competent observer," defined as one who, by training and licensure, is able to assist in making the determination of death. For example:

- a licensed registered, or practical nurse
- an EMT or paramedic
- an intern, resident or other licensed physician
- a clinical fellow
- a chiropractor
- an embalmer or funeral director who completed coursework in vital signs or patient assessment.

Competent observers may not pronounce death themselves. If the competency or accuracy of an observer is in doubt, a physician should personally examine the deceased. The attending physician must complete and sign the death certificate.

Ohio Revised Code section 3705.16 states: "The medical certificate of death shall be completed and signed by the physician who attended the deceased, or by the coroner within 48 hours after death." The Attorney General further defines "attending" by separating the physician who attended the deceased from "any other physician without professional contact with the deceased at or just prior to death." (OAG 76-026). If, for example, a patient dies in the emergency department after

being attended by the emergency physician, the emergency physician should complete and sign the death certificate.

DEATH WITHOUT MEDICAL ATTENDANCE

According to Ohio Administrative Code Rule 3701-5-09, when death occurs without medical attendance, the funeral director or other person who first assumes custody of the dead body must report the death to the coroner who shall investigate the cause of death and complete and sign the death certificate.

CAUSE OF DEATH UNKNOWN

Ohio Administrative Code Rules 3701-5-07 and 3701-5-08 state that when the results of a medical examination to determine the cause of death are not known within five days from the date of death, at that time the attending physician or coroner should sign the death certificate, enter "cause of death pending," and return the certificate to the funeral director in charge of the final disposition. When the cause of death has been determined, the attending physician or coroner must complete a supplementary medical report form and file it with the local registrar of the district in which the death occurred.

PROHIBITIONS

Under Ohio Revised Code section 3705.29, a physician or coroner is prohibited from either purposely making a false statement in a death certificate, or from purposely refusing to provide the required information. A physician or coroner who violates either prohibition can be subjected to a fine, a jail term or both (ORC 3705.99).

AIDS

Ohio Revised Code section 3701.243 places another restriction on physicians: "No person or agency of state or local government that acquires the information while providing any health-care service, or while in the employ of a health-care facility or health-care provider shall disclose or compel another to disclose...the identity of any individual diagnosed as having AIDS or an AIDS-related condition."

The Attorney General, however, states that the prohibition against disclosure of AIDS and HIV information doesn't apply to the coroner who acquires such information while engaged in investigating and reporting the cause of a person's death. The coroner, in other words, may disclose the presence of AIDS or HIV in a death certificate or autopsy report. (OAG 91-074)

CONCLUSION

A physician must use his or her professional judgment when making a pronouncement of death and signing a death certificate. First, the physician must make a determination of death either by personal examination of the body or by assistance from a competent observer.

Second, the physician who attended the deceased should sign and complete the death certificate. Third, the physician who completes the death certificate should assure that he or she has not entered any false information, nor violated the AIDS disclosure law. A physician is legally accountable for both the determination of death and any information placed on the death certificate. ■

Workers' Comp bureau challenged over audits

By Jeffrey S. Senney, JD

Editor's Note: A Dayton attorney cautions physicians to review carefully their BWC audits.

The Ohio Bureau of Workers' Compensation is stepping up its efforts to collect additional insurance premiums. To this end, the bureau is changing its interpretation of "payroll" (without amending the existing definition contained in the regulations) to include items of compensation that have not traditionally been included in the Workers' Compensation payroll base.

The definition of "payroll" has been changed, causing higher insurance premiums.

The current definition of payroll is found in Ohio Administrative Code Section 4121-7-14(C) and states that payroll includes "the entire remuneration allowed by an employer to employees... such as wages, bonuses, commissions, negotiated tips and severance pay (if included in a contract of hire), overtime pay, vacation pay, non-negotiated tips used to supplement the minimum wage requirements, the reasonable value of board, lodging, house or room rent, laundry, food supplies, merchandise, or certificates and orders issued for merchandise or food supplies."

Some of the new items the bureau auditors are now attempting to include within the scope of the existing definition of payroll are:

- 1) Employer contributions to retirement plans;
- 2) Reallocations of forfeitures in retirement plans;
- 3) Distributions to participants of retirement plans;

- 4) Cafeteria plan deferrals;
- 5) Per diem and travel expenses;
- 6) Moving expenses and dis-

- location allowances;
- 7) Tuition reimbursements;
- 8) Food, lodging and travel reimbursement;

- 9) Ordinary income pass-through to partners and "S" corporation shareholders.

Although some of these items probably fall within the existing definition of "payroll," certain of the items clearly do not. Probably the most significant (in terms of

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dollars) and most questionable items now being included in the payroll base by bureau auditors are the contributions, distributions and forfeiture reallocations made with respect to qualified retirement plans.

The effect of including the above described items in the payroll base can be dramatic. For example, we recently challenged a Workers' Compensation audit finding that a lump-sum distribution from a qualified pension plan to a retired employee should have been included in the employer's payroll base for purposes of calculating the Workers' Compensation insurance premium. In this particular case, the employer's payroll base (and therefore insurance premium) would have doubled if the lump-sum distribution was included in payroll. We have recently been advised that the adjudicating committee has rendered a decision in this case that the pension plan contributions and distributions are not to be included in the payroll base for Workers' Compensation insurance premium purposes.

The bureau is also attempting to collect more insurance premiums by performing more audits. The bureau's new plans are to audit each employer in Ohio at least once every five years, to complete every audit within 60 days, and to estimate the payroll base if the necessary records are not available at the time of the audit.

The increased audit activity and the bureau's new interpretation of "payroll" increase significantly the likelihood that employers in Ohio will be subject to assessment for underreporting and underpaying Workers' Compensation insurance premiums. If you are audited, review the audit report carefully with your accountant or attorney before you agree to an audit finding that could dramatically increase your Workers' Compensation insurance premiums. ■

Jeffrey S. Senney, JD is affiliated with the firm of Pickrel, Schaeffer and Ebeling.

Reprinted with permission from the January-February '93 issue of *Dayton Medicine*.

Self-referral – a thing of the past?

"Physician self-referral." If legislators have their way, those words may soon cease to have meaning.

With the passage late last year

of HB 478 – Ohio's health-care reform bill – certain physician referrals of patients for clinical laboratory services became illegal.

"Ohio law is similar to the federal restrictions that apply to referrals for clinical laboratories," says Nancy Gillette, JD, associate staff counsel for the OSMA's Department of Legal Services.

For years, physicians' organizations have grappled with how to tackle the perceived conflict of

interest that accompanies self-referral.

Some argued that physicians' high moral standards would prevent them from referring patients unnecessarily simply for monetary gain. Others weren't so sure, and proposed that physicians at

least disclose to their patients their financial interest, thus giving patients the opportunity to choose another lab or clinic, if desired. Still others believed physicians should simply not refer patients to their outside labs.

AMA'S POSITION

The AMA first studied the issue of self-referral in 1986, when its Council on Ethical and Judicial Affairs issued guidelines and emphasized that physicians should put their patients' interests first. Those guidelines were updated in

1989.

In 1992, the council investigated the matter more thoroughly, and issued new recommendations: 1) Physicians may refer to facilities they have a financial interest in if the physician directly provides care or services at the facility; 2) Physicians may refer to a facility they have a financial interest in, even if they don't provide direct services there, if there is a demonstrated need in the community. (The second recommendation came with several additional requirements, such as financial disclosure and internal utilization review.)

These guidelines, in fact, were reaffirmed in December by the AMA's House of Delegates at its Interim Meeting. And while the AMA's recommendations still apply to physicians operating diagnostic laboratories, HB 478 supplants the AMA recommendations as applied to clinical labs. (HB 478 still allows some referrals, but they have to meet the requirements of the statute.)

ARE DIAGNOSTIC LABS NEXT?

Physicians, then, in order to comply with Ohio's new law, need to become aware of the difference between clinical and diagnostic labs, says Deborah Bahnsen, JD, of OSMA's Ombudsman Department.

"A lab is considered clinical if it conducts tests where they take something from a patient – for example a biopsy or a blood test – for purpose of diagnosing disease," Bahnsen says. "A lab is considered diagnostic if it conducts tests such as X-rays."

"The reason there's so much confusion," she continues, "both for physicians and laypersons, is that on the federal level they've talked about extending the ban to every level."

Whether the ban is extended remains to be seen, what with a new presidential administration and the Ohio Legislature recently reconvening. But some believe change is not far off.

"My impression is that more of this is coming," says Gillette, "but what it will look like, we just don't know." ■

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research teams and clinical specialists of the Comprehensive Cancer Center, which are composed of University graduate programs in chemistry, biological

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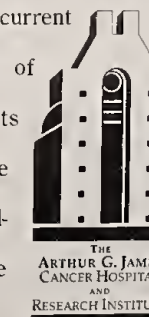
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Workers' Comp CEO speaks with OSMA task force

Members of the OSMA Workers' Compensation Task Force met last month with Wes Trimble, CEO/Administrator of the Ohio Bureau of Workers' Compensation (BWC), to learn about changes recently implemented by BWC and the bureau's plans for the future. Members also took the opportunity to address with Trimble several areas of physician concern.

"We'd like to build an organization that is responsive to the medical community," says Trimble, pointing to recent improvements BWC has made so far, including reducing the backlog of medical provider bills and initiating training programs designed to improve both the service and quality of claims processing.

He also outlined future goals, such as the hiring of four regional physicians to perform medical policy and peer review, that he hopes will improve the bureau's efficiency.

UCR LEVELS CHANGED?

However, a comment Trimble made regarding a planned change in UCR levels by April 1 drew a quick response from task force members who wanted more information about the pending



Workers' Compensation CEO Wes Trimble discusses key issues with members of OSMA's Workers' Compensation Task Force.

change. Other than saying the change was being implemented to save the bureau money, Trimble was unable to be more specific. He did agree, however, to arrange a meeting on March 24 between a small group of Workers' Comp Task Force members and his key staff member responsible for fees to discuss the matter further. The change in UCR levels wasn't the only area of concern committee members addressed with Trimble.

Comments were made that more physician input is needed at

the BWC, not only to sensitize the bureau to problems in the medical community, but also to give physicians the assurance that their concerns are being heard and addressed.

There was also discussion on the bureau's desire to eliminate JCARR, the state agency charged with rule review. While members of the Workers' Comp Task Force were sympathetic to the need to strip a layer of bureaucracy off the BWC process, JCARR remains, for now, the only avenue physicians have for challenging

what they believe to be unfair decisions made by the bureau. There is currently not enough physician input at the bureau for physicians to feel comfortable about eliminating this recourse.

The two groups hope to plan future meetings to improve communications. ■

BWC reform legislation on hold

Despite much talk about reforming the state's Bureau of Workers' Compensation, no bills have been formally introduced as yet into the Ohio Legislature on this matter.

However, Gov. George V. Voinovich has made reform of both Medicaid and the BWC his top priorities for 1993, and there is little doubt that the governor does intend to focus on the need to control the medical cost component of Workers' Comp.

"The OSMA believes it is essential that the Bureau of Workers' Compensation receive and listen to physicians' input, especially on those policies that may affect patient care, including access and reimbursement issues," says Claire Wolfe, MD, chair of OSMA's Committee on Workers' Compensation. "We will review any legislation that may be introduced by these principles." ■

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Fraud investigations on the rise

In Brief: Two payors are beefing up special investigation units to ferret out fraud and abuse.

WORKERS COMP...

The Ohio Bureau of Workers' Compensation (BWC) plans to begin a pilot project this month that will test the use of a special fraud investigations unit in its Cleveland and Columbus offices.

"The investigators will work with claims representatives in BWC service offices and with the Fraud Investigations Unit in Columbus to deter, investigate and prosecute fraud," says Dean Harrison, acting manager of BWC's fraud investigation unit.

This effort represents the unit's new proactive approach to combating fraud. In addition to aggressively investigating and prosecuting fraudulent activity, the unit will also publicize the results of successful prosecutions in hopes that people committing fraud against BWC will stop their illegal activities to avoid prosecution.

Depending on funding, BWC plans to expand the special investigations units statewide in 1994. Based on conservative insurance-industry estimates and past experience, BWC expects that for every dollar spent on fraud investigations, between \$3.50 and \$10 can be saved.

A toll-free hotline, 1(800) 837-1554 has also been established for reporting suspected cases of fraud. Callers may remain anonymous.

MEDICARE...

The Health Care Financing Administration and the Office of the Inspector General of the U.S. Department of Health and Human Services are making it difficult for fraudulent providers to operate. Medicare carriers are accomplishing this objective utilizing full-time fraud investigation units.

Carriers are informing and educating beneficiaries, providers and suppliers concerning Medicare fraud through outreach

programs designed to elevate their awareness of current fraud schemes.

"A fraud investigation unit has been in place at Nationwide-

Medicare for several years," says Jane Wilson, Medicare Fraud and Abuse Information Coordinator (MFAIC). "However, the unit's activity will increase with the initiation of these outreach programs," she says.

Each carrier is now required to designate an MFAIC who will

ensure the networking of Medicare fraud and abuse information. Nationwide appointed Wilson in February.

Nationwide's Provider Relations staff continues to be available to handle questions related to coverage or to answer billing questions. ■



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PRO becoming more educational

Is peer-review becoming more physician-friendly?

On April 1, Peer Review Systems, Inc. began its fourth consecutive Peer Review Organi-

zation contract under the Health Care Financing Administration. At the same time, the organization announced the following modifications that appear to

make the system a bit more palatable to physicians. For example, PRS's new "Fourth Scope of Work" contract would:

- Endorse a more educational, less punitive system. The Quality Intervention Plan "point" system will be re-

placed with an educationally oriented Quality Review Process.

- Analyze patterns of care rather than addressing individual clinical errors.
- Develop guidelines for documentation with input from the medical community.
- Allow physicians to obtain a second-level review, following the PRO's initial quality determination.

This new approach to quality assurance in Medicare has a name – the Health Care Quality Improvement Initiative, and the objective is to develop and share information on patterns and outcomes of care that will lead to

The goal is to move away from correcting individual clinical errors.

measurable improvements for Medicare beneficiaries, say PRS officials. The goal, they add, is to move away from correcting individual clinical errors and toward improving health-care delivery systems as a whole.

Other changes have been proposed in profiling, pattern and variation analysis, data feedback and focusing. The Fourth Scope of Work also includes educational feedback and improvement projects between PRS and physicians.

"Improved health care is the common goal of PRS, HCFA, physicians, providers and Medicare beneficiaries," says PRS Board Chair Donald G. Norris, MD. "Collaboration is mandatory for this improvement to occur. Everyone must work together. This new concerted effort will impact all parties for mutual benefit."

Anyone wishing more information on how to become involved in the PRO Fourth Scope of Work should contact Grant K. Varian, MD, Medical Director at Peer Review Systems, Inc., (614) 895-9900. ■



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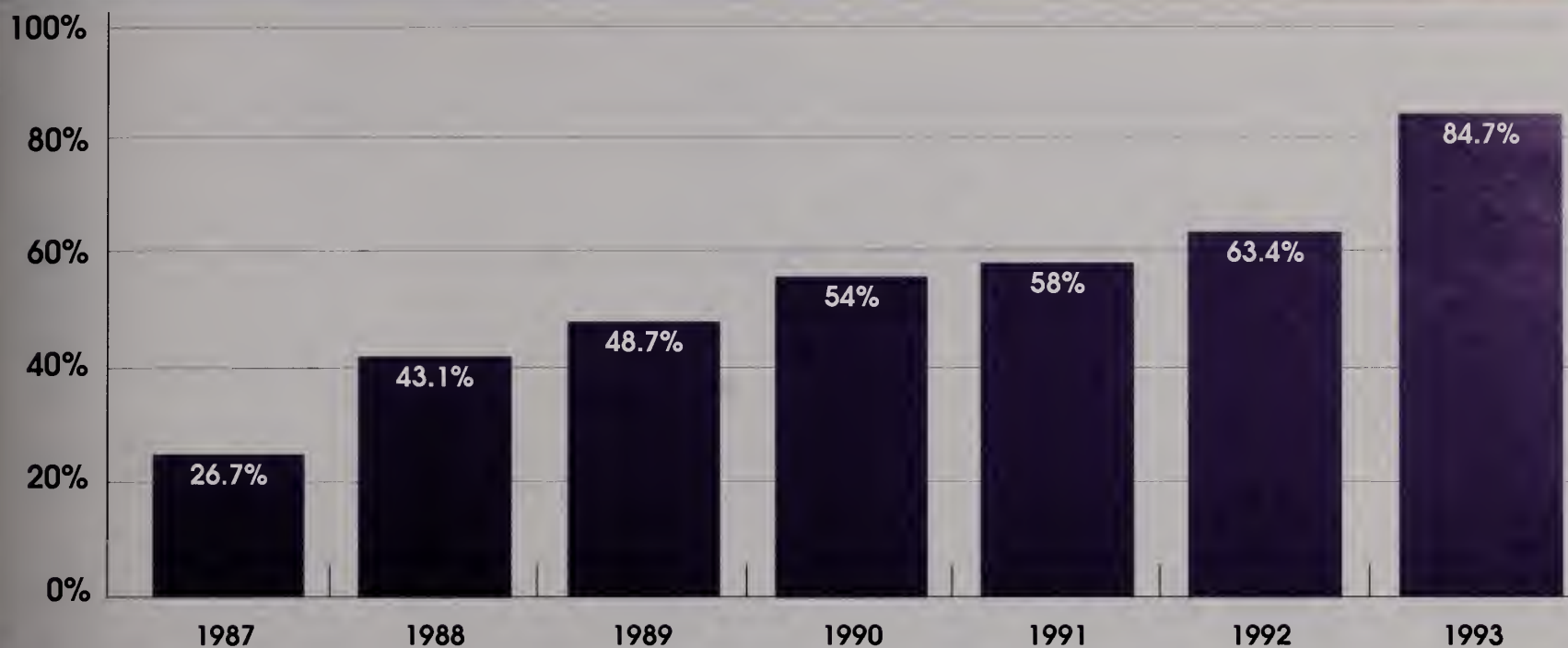
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* The number of physicians participating in the Medicare program has increased dramatically over the past seven years. Figures were provided by Nationwide-Medicare. In addition, Nationwide-Medicare indicates that nearly 95% of all claims are submitted on an assigned basis.



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No word from HCFA on statewide fee schedule

In Brief: OSMA continues to pursue the statewide fee schedule issue, but HCFA has been unresponsive.

The Health Care Financing Administration (HCFA) continues to take a wait-and-see attitude when it comes to changing Ohio to a single payment level for Medicare patients in the state.

The OSMA had hoped that the statewide fee schedule would go into effect starting in January of this year. Now it looks as though Ohio physicians may not see a statewide fee schedule by January 1994, if then.

Though this issue has been a top priority for Ohio physicians, HCFA personnel do not seem to share this urgency. The indifferent attitude taken by HCFA may be attributed to the changing position in Washington or the fact

that there is no HCFA director at the present time.

OSMA'S LETTER UNANSWERED

OSMA's letter to HCFA in January 1993 stating that "the association continues to support a statewide Medicare fee schedule for Ohio and respectfully requests HCFA approval and implementation as soon as possible, but no later than January 1, 1994," has also gone unanswered.



It has been almost a year since the OSMA House of Delegates adopted a resolution in favor of the statewide fee schedule. Since 1965, Ohio has been divided into 15 pricing regions, with reimbursement levels loosely based on expected cost-of-living differences between urban and rural areas.

Early in the process HCFA had indicated that simply passing a

resolution in support of a statewide fee schedule was not enough to induce HCFA to change the payment schedule.

HCFA NEEDED ASSURANCE

HCFA wanted assurance from the counties that stood to "lose" under a statewide system that they supported the idea. The OSMA, at HCFA's request, contacted 15 county medical societies last July and August and asked

them to submit letters of support. Eleven of the 15 counties supported the statewide Medicare fee schedule; two opposed; and two counties didn't respond. These letters were forwarded to HCFA.

William Fry, director of OSMA's Ombudsman Department, says OSMA will stay on top of the statewide fee schedule issue, however the next move must come from HCFA. If no response is received from HCFA by spring, then serious additional pressure, including letters to HCFA from individual physicians, may have to be implemented. ■

Cleveland pay ranks in middle

Cleveland physicians may be paid more than their rural Ohio counterparts under Medicare's current system of reimbursement, but according to a study that appeared in the March 4 issue of the *New England Journal of Medicine*, they fall near the middle of reimbursements paid out to other physicians in large metropolitan areas across the country.

The study used 1989 Medicare claims data to measure the rates of service use for bene-

ficiaries living in the 317 U.S. metropolitan statistical areas. Overall payments to physicians, calculated as the sum of payments for inpatient and outpatient care, averaged \$1,001 per beneficiary and ranged from \$655 in Sheboygan, Wisconsin to \$1,874 in Miami. To the north of Cleveland, in Detroit, physicians there received overall payments of \$1,493 per beneficiary. Overall payments to Cleveland physicians averaged \$1,074 per beneficiary. ■

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If you need assistance with one of these areas, OSMA's Department of Professional Relations and Ombudsman Services may be able to help you. Help is available with claims filing, reimbursement, contract review and analysis, carrier audits and PRO quality intervention reviews.

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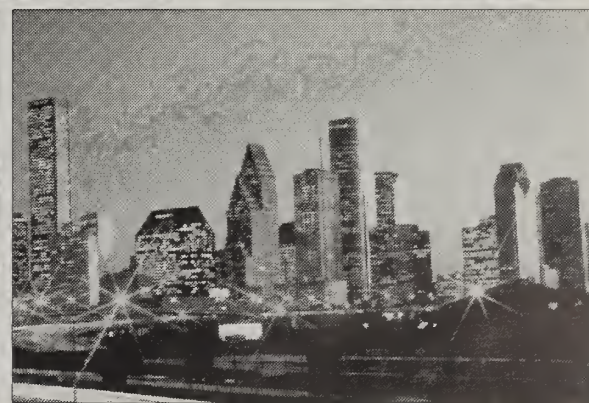
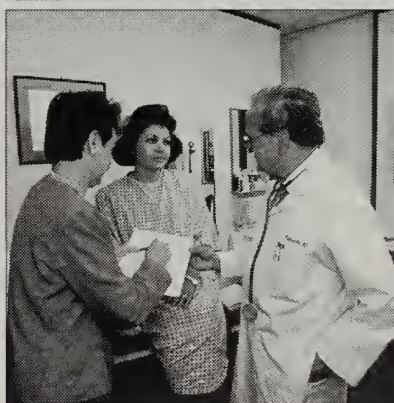
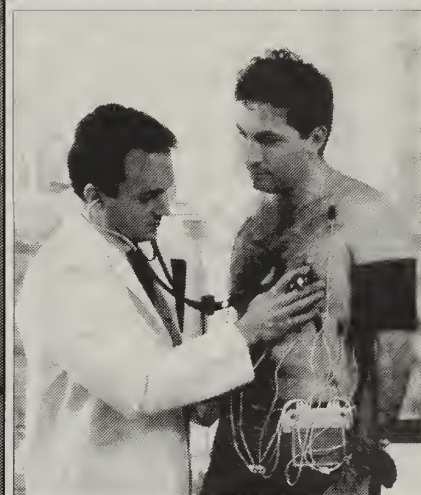
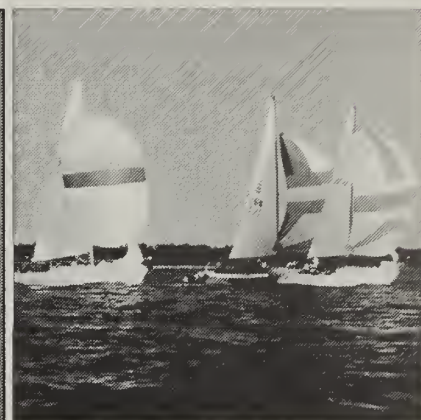
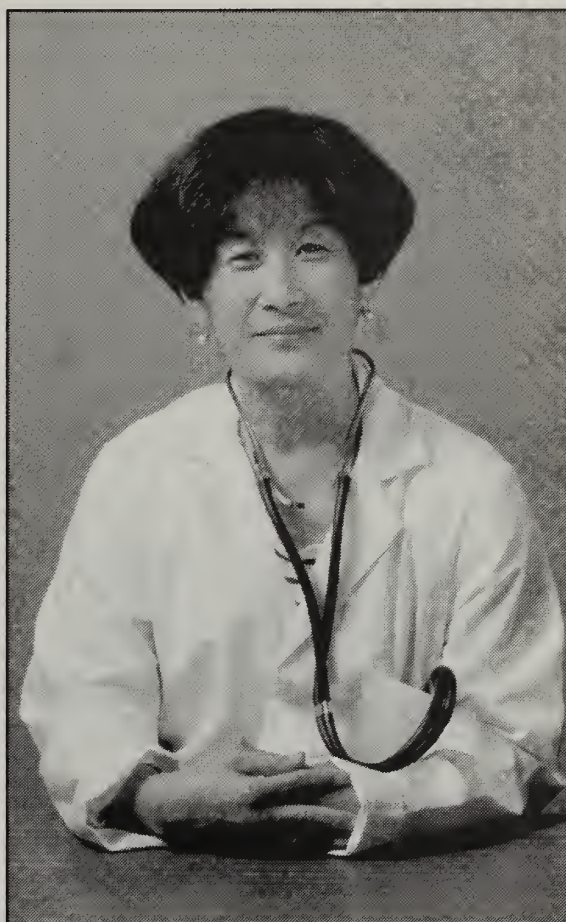
"After years of study, I honestly believed that I was ready to go into practice. I thought that knowledge and experience in medicine was all that I'd need to be a success out there. But, no one ever mentioned that I'd have to be an expert at insurance, law and collections...I'm a doctor, with a substantial amount of money and time invested in being the best that I can be. It didn't take long for me to realize that the time spent in managing my business was time taken away from the really important things in life; my patients, my family, and myself."

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during his campaign and during his transition. In the answers that follow, Dr. Jackson speaks on both federal and state issues, and provides a unique Ohio perspective to both.

A. I would tell them that the job as they know it is changing, but that they have an opportunity to have an impact on how it will change. There is even the possibility that some things will be better as a result of change – that we will be able to offer our children a better environment to practice medicine. Our children will benefit from tort reform, and less paperwork. They will be able to take care of patients without worrying about whether or not those patients are covered by insurance. I think if we can avoid the mistake of a single-payor system, there are benefits to change that we can all derive. Physicians, however, need to stop pining away for the past, and, instead look to the future. They need to participate in this process so they can help make the future of medicine better for everyone – patients and physicians alike. ■

"I think if we can avoid the mistake of a single-payor system, there are benefits we can all derive."

Pilot prescribing programs for nurses making progress

In Brief: Two pilot projects, expanding nurses' scope of practice to include prescribing, were authorized last year under HB 478. Both test sites are, or soon will be, up and running.

Last year's passage of health-care reform bill House Bill 478 set into motion two pilot nurse-prescribing projects in the state.

One has been set up in Cleveland, under Case Western Re-

be soon. The prescribing component, however, will take a bit longer to get off the ground.

"I believe in those states where nurses have been given prescriptive authority, the process has taken six months or longer," says Jane Swart, dean of Wright State University's School of Nursing.

A multidisciplinary team of physicians, nurses and pharmacists are developing the prescribing component of Ohio's test

A team of physicians, nurses and pharmacists are developing the prescribing component of the program.

serve University's School of Nursing. The other is in Fairborn, under Wright State University's School of Nursing.

Both projects have identified their test-site location, which will be staffed by faculty nurse-practitioners. In some cases, care is already being delivered, or will

program, says Swart. They are working collaboratively to establish the rules and regulations that will govern nurse-prescribers at both the Cleveland and Dayton test sites – keeping in mind those prescribing limitations established under HB 478. The team is able to study several models



HHS Secretary in Cleveland

Donna E. Shalala (left), the new U.S. Health and Human Services Secretary, was in Cleveland recently to tour Rainbow Babies and Children's Hospital and to discuss with patients and their families the need for health-care reform. Shalala is a member of the task force, headed by First Lady Hillary Rodham Clinton, that is working on an administrative health-care reform package. She is pictured here with University Hospitals CEO Farah M. Walters, and patient Zach Day.

already formulated on this topic, as well as review the prescribing rules that exist in the nearly 40 states where nurse-practitioners have already been given prescribing powers.

IN DAYTON

Meanwhile, the pilot programs have been established in both schools of nursing.

At Wright State, two primary-care clinics, one in east and one in west Dayton, have been selected, and nurse-practitioners from the faculty at Wright State's Nursing School will soon be delivering care there (if they're not already). Swart says that, in addition to providing primary care and improving access in low-income neighborhoods, the clinics will also provide their patients and the community with health education.

IN CLEVELAND

The Case Western Reserve University's School of Nursing has established a site on Buckeye Road that will serve the Buckeye-Shaker, Woodland and Mt. Pleasant areas, which nursing school Administrator Sandra Deller describes as low-income neighborhoods, composed primarily of

an ethnic-racial mix.

Limited services were expected to be offered this spring by a staff that, like Wright State, is also composed of nurse-practitioners drawn from the school's faculty. One of the primary-care services to be offered at this location will make this site unique – a low-risk birthing service.

FIRST TO OFFER BIRTHING

"We're the first of its kind – the only facility to combine primary care and low-risk birthing," says Deller. She is quick to emphasize the "low risk." "We'll tell our patients that midwifery is not for everyone." There will be two birthing-beds in the facility, and the school is currently working on obtaining its certificate-of-need from the state.

In addition to the nurse-practitioners, trained community outreach workers will also work out of the clinic, says Deller, to increase access and help involve and educate the surrounding community.

OHIO Medicine reports on the progress of these projects to make you aware of all that is occurring on Ohio's health-care scene. We invite your comments. ■

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Nursing homes require new screenings for Medicaid patients

In Brief: In an effort to cut Medicaid costs, the governor now requires an in-person evaluation to determine if Medicaid patients need skilled care. By next year, all nursing home patients will be screened.

Ohio physicians may have a more difficult time now checking their Medicaid patients into nursing homes.

As part of Gov. George Voinovich's efforts to hold down Medicaid costs, the state now requires all Medicaid recipients who apply for admission to a nursing home to undergo a new screening process that will determine whether or not skilled medical care is needed. By next year, all applicants to nursing homes will undergo the screening procedures.

Until the new rule went into effect, Ohio's Department of Human Services did a paper review of applications from Medicaid recipients. Few were rejected, and those that were turned down were often re-worked by hospitals or physicians and resubmitted.

PASSPORT TO RUN SCREENINGS

Evaluations will now be made in person by screeners employed by PASSPORT, those programs run by Ohio's 12 regional councils for the aging. Those patients who fail to pass the screening can apply for PASSPORT, which provides home services for Medicaid-eligible adults. In fact, now physicians and hospitals will have to contact PASSPORT program offices for a screening before they can refer patients directly to a nursing home.

Private-pay patients will be screened because many of them exhaust their own funds, and become Medicaid eligible within four to six months.

Gov. Voinovich hopes to expand the PASSPORT program, as well as the Optional State Supplement program, which provides a subsidy for seniors with incomes too

high to qualify for Medicaid. The subsidy provides some daily living help, but is not meant to cover medical care. ■

Media blitz focuses on depression

The National Mental Health Association will launch a national media campaign this month, April 5-25, on the subject of clinical depression.

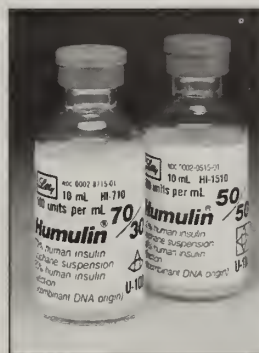
A checklist of symptoms will be presented on television and in print ads, and those who find they suffer from any of the symptoms listed will be en-




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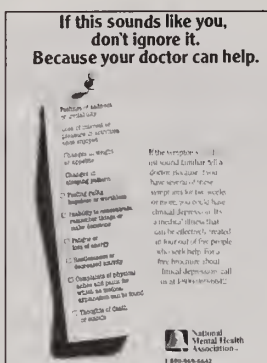
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couraged to see a doctor for help. "The ads' message will be that clinical depression is a medical illness, that effective treatment is available, and those who may suffer from clinical depression should see a doctor," says Phil



Workman, executive director of the Ohio Psychiatric Association. "The trouble, however, is that the ads don't designate what kind of doctor to see, so we can imagine a number of primary care physicians may begin to see these people showing up in their

offices over the next few months." Workman encourages these primary care physicians to refer their patients who need treatment to psychiatrists, and says his organization can help with referrals and also provide any other information about depression

that physicians may need. For further information about the campaign, referrals or education about depression, contact the Ohio Psychiatric Association, 1500 Lake Shore Drive, Columbus, OH 43204-3824 or call 1-(800) 766-OSMA. ■

New malpractice carrier in Ohio

A new malpractice carrier has entered the state. CNA Insurance, a multiline insurance company that operates in all 50 states, is the third largest writer of medical liability insurance coverage in the country.

CNA has offered medical liability for 22 years.

"We have been in professional liability for 40 years and medical liability for 22 years," says Bob Jones, vice president of Professional Liability.

CNA effectively began writing policies, including medical liability policies, in Ohio the first of this year. The company offers current and claims-made coverage and both individual and group practice accounts.

"We look at Ohio as an opportunity to bring an established, solid history of handling medical malpractice claims to the state's physicians," says Julie Ayers, senior account executive, Medical Markets.

CNA joins carriers such as PIE Mutual Insurance Company, the Physicians Insurance Company of Ohio, the Medical Protective Company and others in offering OSMA members comprehensive coverage at competitive rates. ■

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| Pork Tenderloin, trimmed | 139 | 4.1 g | 1.4 g | 67 mg |
| Pork Top Loin Roast (boneless), trimmed | 165 | 6.1 g | 2.2 g | 66 mg |
| Center Loin Chop, trimmed | 172 | 6.9 g | 2.5 g | 70 mg |
| Chicken Thigh, skinless | 178 | 9.2 g | 2.6 g | 81 mg |

*Table refers to 3-oz. cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.¹ According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.¹

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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Bridging the Culture Gap

Students from the Northeastern Ohio Universities College of Medicine take a moment to talk to visiting scholar Marian Gray Secundy, PhD, a professor at Howard University College of Medicine (far right). Secundy recently presented a lecture and workshop at NEOUCOM, designed to expose students to African-American perspectives on health, illness, aging and loss as depicted in literature and poetry. She urged the students and all health-care professionals to bridge the cultural gaps that exist as a result of racial and socioeconomic differences.

Cincy may regulate tanning parlors

Like Hamilton and Toledo, Cincinnati may soon start regulating its tanning facilities. The Cincinnati Department of Health hopes to have in place by spring a local law that would require all tanning salons to:

- have an operating license from the Ohio State Board of Cosmetology.
- provide clients with a "Consumer Information and Consent" form that describes the potential dangers of tanning rays and the posting of chemicals and drugs that may make skin overly sensitive to tanning rays.
- keep more detailed records on changing bulbs, replacement lamps and filters.

The Department of Health also wants to enforce the regulations locally, since the Ohio State Board of Cosmetology, which currently regulates all of the tanning salons in the state, cannot adequately inspect all such businesses. The

city has received some complaints of tanning salons with dirty tanning beds and burned-out bulbs, so the health department looks on the proposed law as a way to respond to complaints, as well as an opportunity to perform routine inspections.

At its 1988 Annual Meeting, the OSMA House of Delegates adopted a resolution, written by Lou Barich, MD, which called for public education on the hazards of tanning parlors. Since then, both Hamilton and Toledo have passed tanning parlor ordinances that regulate their city's salons. ■



Dr. Barich

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About BENO

The Bioethics Network of Ohio (BENO) is a non-profit organization whose members include physicians, nurses and other health care professionals. BENO members come to grips with terminal and long-term care, organ donation, AIDS, addiction, rationing and other contemporary bioethical issues. Your membership is invited. Annual individual membership is \$30.00. To join, or for further information, contact: James E. Reagan, PhD, Center for Ethics, St. Elizabeth Hospital Medical Center, 1044 Belmont Avenue, Youngstown, OH 44501-1790; Telephone (216)746-2255, EXT. 3610; fax (216)744-5926; E-Mail ac725@yfn.ysu.edu

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- B. Determining Decisional Capacity: Hard Cases
- C. Educational for Ethics Committees: Objectives, Resources, Methods
- D. Rationing Health Care: What It Means and Why It Matters
- E. Recognition and Respect of Patients' Diverse Religious and Cultural Values
- F. Holistic Care of the Dying Patient

Please pre-register by Friday, May 21, by check for \$85.00, payable to SEHMC/BENO. Registration includes your 1993 annual individual membership, Conference lunch and refreshment breaks. No refund for cancellations received after Monday, May 24. Please clip out and return to: Patricia McMahon, OSF, St. Ann's Hospital, 500 Cleveland Avenue, Westerville, OH 43081.

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E. WESTBROOK BROWNE, MD, Cincinnati; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1940; age 78; died January 5, 1993; member OSMA and AMA.

WILLARD C. CLARK, JR., MD, Dayton; University of Cincinnati College of Medicine, 1959; age 59; died January 9, 1993; member OSMA and AMA.

JEROME FISHER, MD, Columbus; Ohio State University College of Medicine, 1941; age 80; died December, 1992; member OSMA and AMA.

HAROLD J. FRIEDMAN, MD, Beachwood; Ohio State University College of Medicine, 1932; age 87; died January 7, 1993; member OSMA and AMA.

JOHN J. GEDERT, JR., MD, Clyde; Ohio State University College of Medicine, 1954; age 68; died December 14, 1992; member OSMA and AMA.

GERARD C. GESWEIN, MD, Ironton; University of Cincinnati College of Medicine, 1952; age 72;

died January 4, 1993; member OSMA.

RAYMOND B. GILES, MD, New Philadelphia; Ohio State University College of Medicine, 1952; age 69; died January 2, 1993; member OSMA.

FRANK A. GONZALEZ, MD, Canton; Medical College of Virginia Commonwealth University School of Medicine, Richmond, VA, 1949; age 70; died January 24, 1993; member OSMA and AMA.

JOHN G. GUJU, MD, Youngstown; Medical College of Wisconsin, Milwaukee, WI, 1947; age 68; died January 31, 1993; member OSMA and AMA.

LESTER HERGESHEIMER, MD, Yellow Springs; University of Pennsylvania School of Medicine, Philadelphia, PA, 1926; age 91; died December 25, 1992; member OSMA.

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NEJDAT P. MULLA, MD, Wildwood Crest, NJ; Faculte de Medicine de Universitat de Geneva, Geneva, Switzerland, 1952; age 72; died December 27, 1992; member OSMA and AMA.

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KARL S. ULICNY, MD, Salem; Ohio State University College of Medicine, 1938; age 78; died January 20, 1993; member OSMA and AMA.

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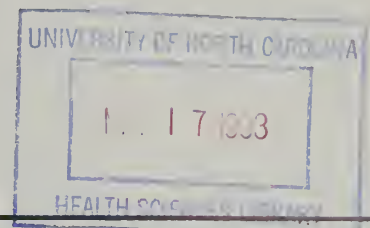
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News for Members of the Ohio State Medical Association

Health-care reform for all a priority OSMA health task force meets

In Brief: Point by point, the OSMA's Task Force on Health-Care Reform is shaping the proposal it will take to the Statehouse as the basis for statewide health-care reform.

At its first meeting last month, the OSMA Task Force on Health-Care Reform laid the first brick of the comprehensive, plausible state health reform plan that the OSMA hopes to take to the Statehouse later this year.

Initially, at least, members have decided that every Ohio citizen should be guaranteed a health-care plan.

"We have to extend the boundaries of our proposal beyond the patient," says task force member Teresa Long, MD, Columbus. "We need to include those who are presently out of the health-care system."

Using a technique known as the "Blendon Construct," which asks pointed questions about health-



Photo by Jack Kustron

Members of OSMA's Task Force on Health-Care Reform met recently for the first time at association headquarters.

care reform, the group came to its first conclusion fairly quickly. In subsequent meetings, however, task force members will wrestle with issues such as what form this guaranteed plan should take and how it will be financed.

WHY NOW?

"I've had questions about why our task force is meeting now, before we've seen what comes

See **TASK FORCE** page 2

BWC reduces fees

In Brief: BWC's recent announcement that it was reducing its UCR levels prompted OSMA's Workers' Comp Task Force to raise some questions.

A fee reduction implemented April 1 by the Bureau of Workers' Compensation could impact many Ohio physicians

caring for injured workers. Unfortunately, for many physicians, this may be the first they've heard of the change.

Representatives from the OSMA Workers' Compensation Task Force met with BWC key staff members about the new UCR levels a week prior to the fee structure change to find out about the pending changes and to offer input.

According to BWC officials, a provider bulletin was sent in February to all physicians explaining that there was to be a revision of the UCR payment schedule. However, the information was not prominently featured in the letter and may have been missed by many who

See **BWC** page 2

OSMA to sell PICO its shares

The OSMA has reached an agreement in principle to sell its Class B shares in the Pickerington-based Physicians Insurance Company of Ohio to PICO for \$1 million. This agreement may be subject to approval by the Ohio Department of Insurance and others.

"We are satisfied with the agreement," says OSMA President Stanley J. Lucas, MD. "We felt it was time for the association to sell its interest in PICO. This agreement allows us to do that."

The completion of the proposed transaction is expected in mid-June. ■

Inside

ANNUAL MEETING:

OSMA delegates are expected to consider health-care and tort reform when they convene at the Annual Meeting, to be held in Cleveland May 14-17. **2**

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GROUP PRACTICES: With more Ohio physicians moving into group practices, the OSMA is taking a closer look at how it can help meet the needs of this growing audience. **10**



Dr. Su-Pa Kang

DR. KANG'S TRIP: OSMA's Fourth District Councilor reflects on his recent trip to Washington, where he participated in the AMA's "New Partnership" rally. **17**

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Button Draws Attention to Family Violence

House of Delegates members will be asked to wear the Ohio Physicians' Family Violence Prevention Project button at the OSMA Annual Meeting May 14-16 in Cleveland to demonstrate their support for the campaign. If you will not be attending the meeting, but would like a button, you may contact the OSMA Department of Communications at 1-(800) 766-OSMA.

Task Force...From page 1

out of Washington," says Walter A. Reiling, Jr., MD, OSMA president-elect and task force chair. "But it's my impression that the report from the First Lady's task force will be merely a framework. State legislators will be asked to fill in the gaps with their own unique agendas – and this time, when health-care reform is proposed at the Statehouse, we want

"If we don't have a consensus, we won't be players on the field."

to be ready."

John Van Doorn, OSMA's legislative director, told task force members that there is likely to be a brief interim between the time the federal proposal is presented and when state legislators will act.

"Right now, there is no omnibus health-reform legislation at the Statehouse, and there is none on the horizon. This affords us a window of opportunity," says Van Doorn. "We can point the direction that state health reform should take."

Precedent for such action has already been set by the State Medical Society of Wisconsin,

says John Patchett, JD, with the AMA's State Health Reform Action Group, and a guest speaker at the task force meeting. "The Wisconsin task force has just issued its report, and because it contains proposals that are not necessarily comfortable for physicians, it will probably be taken seriously by legislators. Wisconsin physicians have shown they can be players – that they can go beyond their own parochial interests."

The need to look beyond self-interest is an important one, and why, Dr. Reiling says, task force members have been selected from diverse specialties, geographic location and background.

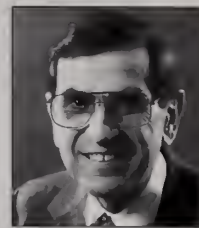
"We will try to forge a consensus that is representative of all of the state's physicians," says Dr. Reiling. He encourages task force members to solicit input from other OSMA members toward that end. Still, he recognizes the need for compromise.

"If we don't have a consensus, we won't be players on the field," says Dr. Reiling, "and this time, we have to be players. No matter what Washington does, there will still be a number of health-care issues to be resolved in this state. We have to be prepared to address those. If we miss this opportunity, then I think we'll be making a serious mistake." ■

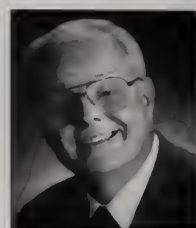
Annual Meeting in Cleveland

OSMA's Annual Meeting will be held May 14-17 at the Stouffer Tower City Plaza Hotel in Cleveland. It will begin Friday night with the Opening Session, presided over by OSMA President Stanley J. Lucas, MD. Walter A. Reiling, Jr., MD, Dayton, will be installed as the association's new president, assuming his duties at the close of this year's meeting.

Resolutions Committees will meet Saturday to hear debate on 70+ resolutions to be considered at the House's Final Session on Sunday. Saturday night, Rep. Patrick A. Sweeney (D-Cleve-



Dr. Lucas



Dr. Reiling

land) will speak at OMPAC's annual dinner.

Sunday will feature voting on resolutions, for AMA delegates, alternates and for OSMA's new president-elect. Claire Wolfe, MD, Columbus is running unopposed for the office. ■

BWC...From page 1

received it. Those who did read about the proposed revision were probably frustrated by a lack of accompanying details.

"I guarantee that 99% of physicians did not pay one iota of attention to the letter," says task force member James J. Powers, MD, Columbus. "Physicians did not know about this. It's going to be a shock." It could even mean that physicians will be discouraged from getting involving with BWC in the future, he added.

Some task force members stated that the first hint they had about a possible change in the bureau's UCR levels came in early March when Wes Trimble, CEO of Workers' Compensation, met with the group and mentioned it during that meeting. Other task force members agreed that the revised UCR levels were likely to trigger negative comments and animosity from physicians.

WHO'S IMPACTED BY CHANGE

BWC estimates that 12,000 of the 14,131 practitioners who billed BWC in the past year could see their fees for services reduced not more than \$2,000. That figure reflects the 20% reduction in the maximum fee under the new schedule.

The BWC justifies its new UCR structure as a cost-saving measure, pointing out that the bureau will save \$20 million.

BWC representatives also claim that the cost of medical care provided through Workers' Compensation is growing at a rate that's considerably higher than either the rate of inflation or the increase in health-care costs in

general. In order for the system to remain affordable, according to BWC officials, these increases must be brought under control – especially the medical component, which according to BWC figures has tripled in the last 10 years. BWC figures show that close to \$700 million was paid in medical dollars in 1991, compared to \$200 million in 1981. In 1992, 38.6¢ of every dollar went to medical cost, while 64.4¢ went to compensation benefits. By the year 2000, BWC projects 50¢ will go to medical and 50¢ to compensation.

FEE SCHEDULE NEEDED

Claire Wolfe, MD, OSMA Workers' Compensation Task Force chair, suggested that physicians be provided with a fee schedule that would clearly show what the new UCR reimbursement would mean to physicians relative to their general charges. BWC officials seemed willing to cooperate, but said Medirisk, the contracting agent hired by BWC to establish in 1991 an Ohio UCR system, will not allow such data to be disclosed.

It appears, then, that after April 1 physicians will have to monitor their billing and receipts carefully so they may evaluate the effect of the new UCR rates on their own practice.

A suggestion by task force members to delay implementing the new UCR levels until 1994, when new provider enrollment contracts are expected to be available, was dismissed by BWC officials who said that the bureau could not afford to wait. ■

Budget bill changes affect physician licensing, Medicaid

In Brief: Ohio's biennial budget bill contains several provisions of interest to physicians. Some of these have been altered, however, on their way to the Senate.

Since the state's biennial budget bill has fairly bristled with provisions affecting Ohio physicians, the OSMA has kept close track of its progress through the House and will continue to watch it as it moves to the Senate.

As it passed the House last month, the bill was already showing signs of some significant change. Here is an update, then, of those matters of greatest interest to members.

LICENSE FEE INCREASE

The Ohio State Medical Board's proposal to increase biennial license fees to \$300 was lowered to \$200 in the House. That, of course, is the same figure that

OSMA Council members said last March they would be willing to support if a fee increase proved necessary. The board, however, has portrayed that amount as only large enough to maintain its present operations, and not enough to expand into other programs as they wish. The board is expected to continue to argue for the higher sum in the Senate, while the OSMA will lobby for no more than \$200.

MEDICAID REIMBURSEMENTS

Thanks to the OSMA and other physician groups, the budget bill continues to retain a provision increasing the amount of Medicaid reimbursement for physicians – yet that increase does not

come without some control. Before the bill moved on to the Senate, the House added an amendment that places Medicaid patients under a primary care case management system.

NON-PHYSICIAN DIRECTOR

In its continuing efforts to find new ways to lower costs, the state suggested in its budget bill that the physician director of the Ohio Department of Health might be replaced with a lower-salaried masters of public health candidate. Peter Somani, MD, the ODH's current director, addressed this issue at the March Council meeting: "I believe the health department needs a physician at the helm. Only a physician can fully understand all the complexities that we work with on a



daily basis in our offices. Certainly, it's appropriate to have public health professionals in the department, but the director must deal with other issues of medical care – not just public health." The House restored the physician designation.

NURSE PILOT PROJECT

A third independent nurse pilot project, proposed for Columbus, remains in the House version of the bill despite OSMA's opposition. The project would be in addition to two similar projects, under way in Cleveland and Dayton, that expand nurses' scope of practice to include prescribing. The OSMA will continue to work at removing this provision.

OHIO Medicine will keep you informed of the budget's progression through the Senate. If you have questions about any of the items mentioned above, address them to OSMA's Department of Legislation, 1-(800) 766-OSMA. ■

OSMA: Bill prohibiting doctor-patient sex unnecessary

In Brief: The Legislature wants to prohibit doctor-patient sexual relations. The OSMA believes the bill is unnecessary since ethical guidelines already forbid these actions.

The OSMA is well aware of the public relations difficulty of opposing a bill that prohibits sexual relationships between doctors and their patients. Nevertheless, after careful review of House Bill 102, the bill that prohibits doctor-patient sex, OSMA's Committee on State Legislation has decided not to support it.

"The committee believes this bill is unnecessary," explains John Van Doorn, director of OSMA's Department of Legislation. "Ethical guidelines already forbid this type of misconduct."

Katrina English, JD, director of Legal Services, has recently presented a similar argument in the *Pons* case, a case that involved an Ohio physician, disciplined by

the state medical board, because he had sexual relations with his patient.

"We didn't argue that this was something doctors should be allowed to do. We don't condone these actions, and we believe that,

Medical ethical guidelines already forbid the practice.

ethically, physicians should not become involved with their patients until they have terminated the doctor-patient relationship," says English. "Certainly the OSMA recognizes that the medical board has the authority to discipline doctors who don't comply with these ethical guidelines. However, in the *Pons* case, we believed that the medical

board did not handle the procedure of disciplining the doctor correctly."

A TENUOUS POSITION

Yet no matter how valid such arguments may be – either at the Legislature or in court – they place the OSMA in a tenuous public relations position. It's difficult to oppose a bill that prohibits an action that is so obviously in violation of medical ethics.

"The bill has become something of a celebrity cause," reports Van Doorn. "It has gathered wide support, especially among women's groups. Still, the committee believes it's unnecessary, and also wonders why physicians were the only professionals who have been singled out for this action."

The OSMA is working with the bill's sponsor, Rep. Ray Miller (D-Columbus), to try to explain the association's complicated position. ■

CON law being reconsidered

The certificate-of-need (CON) law, which mandates pre-approval, based on need, of health-care facilities before they are built or developed, expires later this year, but the Ohio Legislature already has plans to keep the program active.

House Bill 260, introduced by Rep. Paul Jones (D-Ravenna), sets up a continuation of the state's current CON program, but a study group chaired by Sen. Grace Drake (R-Solon) is in the process of rethinking and rewriting the law to make the program more effective.

Among the study group members is John A. Devany, MD, Toledo, an OSMA past president who is representing the interests of OSMA.

OHIO Medicine will bring you more news about the CON legislation as the year progresses. ■

OSMA task force considers tort reform

Caps on pain and suffering, arbitration, contingency fees and practice parameters were among the various tort reform proposals considered recently by members of the OSMA's Task Force on Professional Liability, chaired by Arnold Schuring, MD, Warren.

Since tort reform is likely to be a part of the proposal the association's Task Force on Health-Care Reform (see front-page story) will present to legislators, it fell to the professional liability task force to narrow the field of tort reform options available:

- Caps on noneconomic damages
- Structured/periodic settlements and
- Subtracting collateral source payments from awards

CAPS ON PAIN AND SUFFERING

Noneconomic damages are those not associated with eco-

nomic loss.

"They're the pain and suffering damages awarded by juries – frequently in large dollar amounts," explains Cynthia Snyder, JD, associate director of OSMA's Legislative Department.

Two years ago, the Ohio Supreme Court struck down a \$200,000 cap on noneconomic damages that the OSMA had successfully written into law. The Supreme Court found that the cap unfairly penalized injured plaintiffs and was therefore unconstitutional.

Task force members disagreed, and pointed out that caps have been upheld by public courts in both California and Indiana.

They would like to see the language redrafted into legislation, "although we recognize that the courts may challenge it again," says Dr. Schuring.

Structured settlements provide payment for future care on a

periodic basis, rather than as one lump-sum payment to injured parties.

Members of the task force were very receptive to the idea, and even suggested that structured settlements be made mandatory over a certain dollar amount rather than at the judge's discretion, as the law is currently written.

"It's really a matter of social justice," says Lee Vesper, MD, Cincinnati. As he points out, such settlements might stop abuse of the award by caretakers or others who spend the money frivolously, then leave the injured party in the care of the state.

COLLATERAL SOURCE

Payments an injured party receives from Workers' Compensation, Medicare Part A or other employee benefits may not currently be offset against the total amount of damages awarded by the court.

Task force members would like to see the amount paid a plaintiff

by these benefit programs subtracted from the judgment, as money already received or to be paid to the plaintiff. Such a measure, task force members reasoned, would exclude the "double-dipping" that currently exists.

Other reform measures considered by the task force included:

- limiting lawyers' contingency fees and
- an Ohio Hospital Association proposal to distinguish the hospital's liability from that of its staff physicians, so that all parties are separately liable.

Professional liability task force members expect discussions on tort reform measures to continue before recommendations are finally made to the Task Force on Health-Care Reform.

Action has been initiated, however, and OSMA continues to consider tort reform a legislative priority. ■

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Bill to end discrimination by HMOs

In Brief: A bill designed to prohibit HMOs from discriminating against minority physicians has expanded into an investigation of HMO practices by a House subcommittee.

When Rep. Otto Beatty, Jr. (D-Columbus) introduced House Bill 28, the bill's purpose was to prohibit managed care programs from discriminating against minority physicians. Since then, a House insurance subcommittee has decided to broaden the bill's scope, after hearing other complaints about HMO practices.

Rep. Mike Stinziano (D-Columbus) is chairing the five-member subcommittee, which includes the bill's sponsor, Rep. Beatty, as well as Reps. Karen Doty (D-Akron), Michael Fox (R-Hamilton) and J. Donald Mottley

(R-Carrollton).

According to Dan Leite, assistant director of OSMA's Department of Legislation, the subcommittee will study five major issues:

- minority and community physician issues
- gag clauses that prevent doctors from criticizing HMOs and limit what a physician may tell his/her patient.
- the effect of out-of-state ownership of Ohio HMOs
- the solvency of HMOs and how that affects patients, and
- the number and types of complaints filed about HMOs with the Department of Insurance.

Physician volunteers may get immunity

Ohio physicians who volunteer their services at clinics and shelters may finally be given some immunity from liability if either of two bills, recently introduced at the Statehouse, are passed.

House Bill 270 is sponsored by Rep. Marc Guthrie (D-Newark), and Senate Bill 100 is sponsored by Sen. Grace Drake (R-Solon).

Both bills would provide qualified immunity from liability

for physicians and other health-care personnel who volunteer their services in clinics, homeless shelters and other such facilities.

Although the OSMA has not yet taken a position on these bills, it has supported similar legislation in the past and is expected to come out in favor of both proposals. ■

PRESELECTION PROHIBITED

One of the bill's current provisions would prohibit pre-selecting doctors.

"It would require the HMOs to admit every provider who expressed interest in joining the plan," says Leite.

In an article in the *Columbus Dispatch*, Kathleen Darling, executive director of the HMO association, was quoted as saying her members don't oppose the

anti-discrimination provision, but the one that prohibits preselection guts the concept of HMOs – that is, managed care, aimed at holding down costs.

"The OSMA looks at this investigation as an opportunity to present a broad range of concerns on managed care," says Leite.

OHIO Medicine will keep you updated on the subcommittee's proceedings and its ultimate effect on HB 28. ■

Current legislation updated

Last month, *OHIO Medicine* listed those health-care bills before the state Legislature, and OSMA's position on each. Here is an update on some of those bills:

House Bill 11 – Execution by Lethal Injection

This bill has passed the House and now awaits hearings in the Senate. The OSMA has taken no position on this bill, but is offering technical assistance.

House Bill 183 – Mandatory Treatment of Medicaid Patients

This bill was featured in its own story last month, although it was still under OSMA review.

However, the OSMA now believes it has convinced the bill's sponsor, Rep. Paul Jones (D-Ravenna), that mandating physicians to treat Medicaid patients is an unworkable solution to the problem.

Senate Bill 29 – Corporal Punishment

Actively supported by the OSMA, this bill has passed the Senate and is now being considered by the House. ■

Update

Amish exemption

Ohio Rep. Doug White (R-Manchester) has introduced House Bill 159, which would exempt Amish and Mennonites from participating in the state's Workers' Compensation system. Rep. White points out that the estimated 2,500 members of those religious groups in the state take care of their own members and don't believe in accepting insurance from public or private sources.

The Internal Revenue Service recently adopted procedures

that allow members of these sects to seek exclusion from self-employment tax, and Pennsylvania has allowed its large Amish community to exclude itself from paying insurance benefits since 1975.

The Bureau of Workers' Compensation has expressed concern that fringe religious orders will seek similar exemptions, but Rep. White stipulates that the sect or religion would have to be in existence since 1950 in order to qualify for the exemption. ■

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RELIABLE

PRESIDENT'S PERSPECTIVES

Recalling the year of the "C"

The year as president of the Ohio State Medical Association sped by in meteoric fashion. I will recall this year as "the year of the 'C.'" This is the time of major **change** of health care, with enough **challenge** to satisfy anyone's longing for proaction.

We must **continue** to **communi-**cate our **concerns** to all who will listen and also **calculate** the benefits versus risks involved in reform. **Creativity** and **compromise** will certainly be important as **Congress** decides these issues.

We should not be too **critical** of **Clinton's** **concepts** before they are on the table, but we have already learned that as a **candidate**, many promises were made that cannot and will not be fulfilled.

Although the administration has not **confided** to us regarding

their **course of action**, we know that **cost-control** with possibly price freeze and **competitive** managed health care will be factors in their program.

The **citizens** of this **country** are entitled to **continued** quality medical attention given by physicians on a one-to-one basis with **consideration** and **compassion** for their patients. Foremost, the patients are entitled to their independent **choice** of physician.

The AMA has moved sharply from its prior **conservatism** to a more progressive posture. They have recognized the approaching **crisis** and have developed a set of **criteria for change**, a program named "Health Access America."

There is no **complacency** in organized medicine. During the past few years, the House of Delegates of the AMA has been

concerned and has debated over such issues as physicians' **conflict of interest** in self-owned facilities and RBRVS with imposed **conversion factors**. The need for **continued charity care** of the indigent is also recognized.

We have heard the complaints of the public, and there is no **comfort** in using old **cliches** as a **cover-up**. We are **confident** that new solutions to the health system will be found.

Most important, despite differences of opinion, physicians must maintain unity within the profession and optimism for the future.

I look forward to working with the new leadership of the OSMA.

Your next president, Walter A. Reiling, Jr., MD, is a person of great **character** and **courage** and will be an excellent leader. The **Council** this year has been

superb and responded wholeheartedly to every **call**. The **cooperation** and assistance of staff has been

outstanding, and special thanks to Brent Mulgrew, executive director.

The **calendar** moves on, and I hope to "C" all my OSMA friends often and to continue working for what we know is right for patient **care**. ■



Stanley J. Lucas, MD

AUXILIARY REPORT

Do we need to update ourselves?

Recently, I took the time to look through some articles written by medical auxiliary presidents from the county, state and national organizations. My sampling of readings went back many years, with an emphasis on the past 10. It was amazing to me the number of times that I read the words "change" and "future." Now, here I am in 1993, completing my year as president of the state auxiliary, and I am writing the same words. Constant change is here to stay. As we reflect on the past 53 years of the Ohio State Medical Association Auxiliary, it becomes imperative that we remold our organization in order to meet the changing membership. Our future is the accomplishment of what we do today.

Our years of existence have taken us from an organization of a few volunteer women to a

much larger group that includes an ever-increasing number of us with careers. And with 50% or more of today's medical students being women, the male spouse offers an especially interesting membership challenge.

National studies have indicated that younger spouses are reluctant to join an "auxiliary." And the younger spouse is the future of the survival of the organization. Ohio's medical auxiliary will respond to these sentiments at our annual meeting this month, as we propose changing the name "Auxiliary" to "Alliance" – just as our national group has done. Alliance connotes partnership, and I truly feel that partnership better describes this organization as it is today. As physicians' spouses, we are partners in medicine.

We must be cognizant of the

traditional members of our organization, as they are the backbone and represent true volunteer power, but the world and our volunteers are changing rapidly; we must change, too.

The year has passed quickly, and I wish to thank the OSMA leadership and staff for all of their help and encouragement. A very special thanks to Brent Mulgrew, who has helped in so many ways, particularly in helping set priorities and charting the course for the future of the auxiliary.

It would be impossible to do this job without the assistance of Auxiliary Executive Director Carol Wenger. Although Carol is employed part time by the auxiliary, she does a full-time job. She is a friend to auxiliaries across the state, and is a voice of calm to the officers and board. She frequently goes unrecognized, and I wanted

the *OHIO Medicine* audience to know that the auxiliary has a terrific executive director.

There is still much work to do for our organization, but I now turn my hopes and dreams over to our next OSMA-A president, Valerie Vollmer, who will be writing the future articles under "Auxiliary Voice." I wish Valerie well as she continues the work as leader of the state auxiliary (alliance). It has been a privilege to serve. ■



Sara Rich, President

SECOND OPINION

It's 2003 – will CLIA-'98 ships pass muster?

It was 1998 when the U.S. Congress passed the Commercial and Luxury Vessel Improvement Act (known as CLIA-'98) in an attempt to put an end to disasters at sea. However, it took four more years to develop the administrative regulations needed to enforce it. Now, in the year 2003, it has been operational for a year, and we have done an investigation to determine the impact of the new law on the mariners directly affected by it. You may be surprised by our findings – or you may not be!

LARGE SHIPS

Large ships are covered differently in the new regulations than smaller pleasure boats, being placed in a "highly complex" category. Some tanker groundings had led to massive oil spills, and the federal government had concluded that tighter controls on navigation practices were needed to prevent such catastrophes in the future.

The captain of the giant tanker, Noxxe Zedlav, gave us a tour of his vessel's wheel-room. We saw the sophisticated navigational equipment that has been on board since the ship was launched many years ago, as well as the redundant devices and procedures required by CLIA-'98. We also met the clerks who are on duty around the clock whenever the vessel is under way, recording the results of the mandated Quirk Containment (QC) and Provide Tidyness (PT) programs, checking printouts of the statistical calculations done by the onboard computer, and generating reports to be scrutinized by the government inspectors who may appear by helicopter, unannounced, whenever the weather permits. The captain was unable to identify any way in which operations were truly safer than before, however. "Occasional foul-ups occur when human nature is involved," he said. "We just document them with a higher degree of sophistication now."

MODEST CRUISERS

The situation was quite different when we interviewed the owner of a more modest, family-sized cruiser. He too was required to obey the "moderately complex" standards. Finding room for the newly required navigation equipment on such a small boat, where every space was already utilized, proved to be difficult. He finally solved the problem by removing the vessel's "head" and

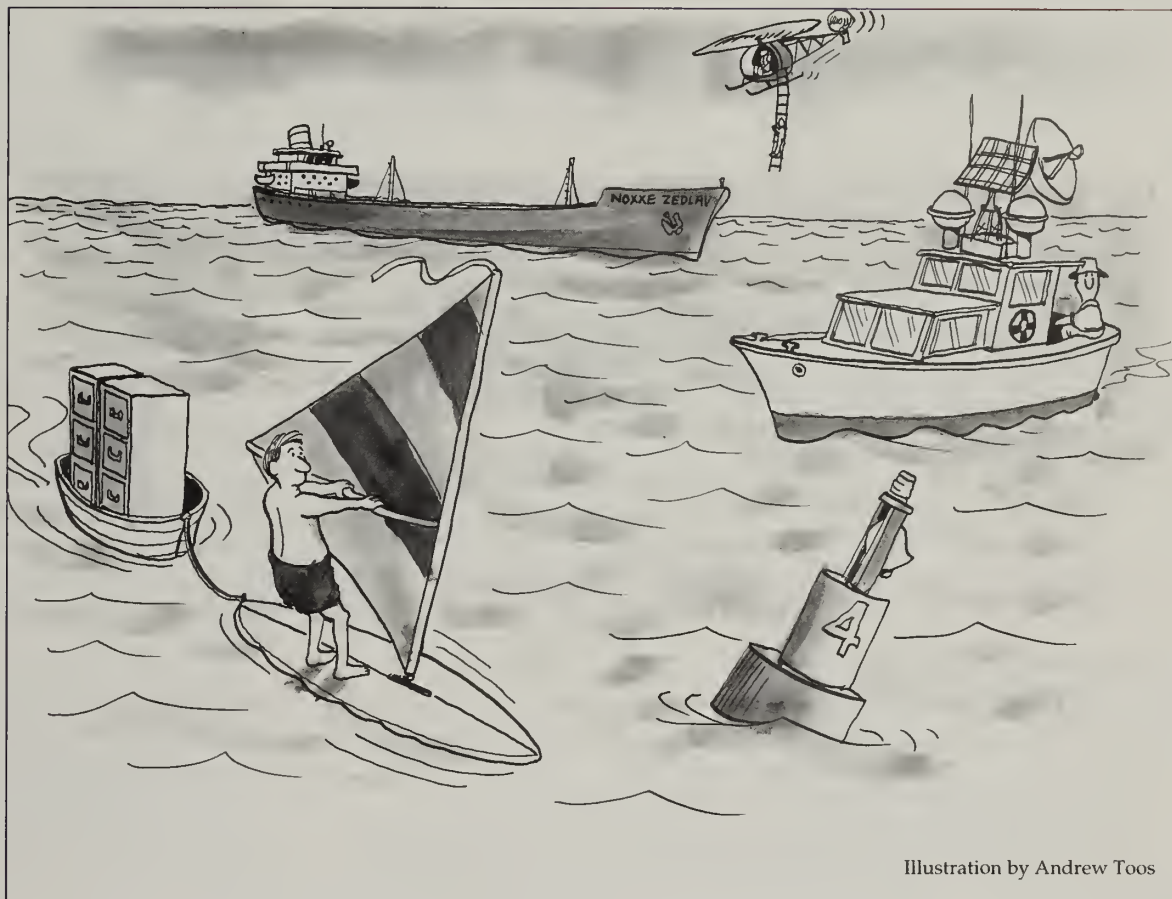


Illustration by Andrew Toos

installing the instruments right next to the washbowl. The toilet paper holder was replaced by a longer device to hold rolls of computer paper. "One's about as useful as the other," said the skipper.

SAILBOARDS

Our last interview was with the owner of a sailboard, which is little more than a surfboard with a sail on it. "I qualified for the 'waived' category under CLIA-'98," he said, "because my boat is less than 10 feet long and doesn't have a motor. However, I still have to register and pay a substantial fee every two years, and I must keep navigation records on board at all times, even though I never sail out of sight of land."

His solution to the record-keeping requirements was ingenious, but not completely satisfactory. He bought a small dinghy, mounted a waterproof filing cabinet in it and towed it behind his sailboard whenever he went out. When we asked how this had worked for him, he said, "It really slowed me down, but I kept going until an inspector showed up in a power boat one day while

I was out sailing. At first I thought he was going to try to get on board with me, which would have assured a quick swim for both of us. Instead, he climbed into the dinghy, opened the filing cabinet, inspected my records and wrote me up because I didn't have a compass on board. That's when I decided to give up sailing."

Lest readers think that all is not well with CLIA-'98, we must point out that the new law has had a substantial effect in reducing the nation's unemployment rate because so many people are being recruited to work as inspectors. Applicants must be able to read and write – and preference is given to those who can swim. ■

Since the author must also deal with CLIA inspectors, this article was submitted anonymously.

OHIO Medicine welcomes articles for consideration as Second Opinion pieces, but reserves the right to edit as necessary and to reject those pieces not suited for an OSMA publication.

LETTERS TO THE EDITOR

Thanks to colleague who told OSHA story

To the Editor:

We are all indebted to Dr. Anand for his unselfish sharing of his experience with OSHA. The information is invaluable. Thank you.

DAVID H. GREGOR, MD
Columbus

License fees increase opposed

To the Editor:

This is in response to the proposed 100% increase in license fees that was mentioned in the April issue of *OHIO Medicine*. I would like to go on record as being opposed to such an increase in fees, especially since the licensing fee was recently raised from \$100 to \$160.

STEPHEN R. RICHARDS, MD
Columbus

Medical board increasing fees unacceptable

To the Editor:

The April 1993 *OHIO Medicine* edition was read today, and the legislative proposal to increase license fees was reviewed.

On first reading, my gut reaction is to say no.

On reading it the second time, my reaction again is no.

I read the article for the third time. I see no concrete need for the state medical board to have this money. They do not do anything for us to begin with, and it is just a financial attempt to increase their administrative staff for more harassment.

Three times, I feel no. I emphasize that this is something that should not be done. If there is any way that I can write to a legislator expressing my views when the legislation comes up, I would like to do so.

ROBERT M. HESS, MD
Zanesville

Malpractice figures questioned

To the Editor:

I feel that comments are in order regarding your recent article "Malpractice Misperceived" in the March issue.

First of all, I note that there were a total of 8,231 malpractice "cases." Of these, there were payments in 3,514. The question here is, what constitutes a "case"? Frequently, statistics are maintained on a number of "claims," with each individual physician, institution or corporation counted as a separate entity. However, if the more traditional definition of "case" is used, the number might be considerably smaller.

The fact that juries found in favor of physicians 76% of the time may be more a reflection of the large number of cases settled out of, rather than in, court. Frequently, I have witnessed alleged malpractice cases against physicians that are settled for reasons clearly not related to care. Frankly, I do not believe there is any misperception on the part of physicians regarding the ever-present danger of a malpractice suit, regardless of the quality of care. I am convinced that the cost of "defensive medicine" is many times the published estimates.

At a time when medical education is at its highest level, there is mandatory CME, multiple peer review mechanisms and a clear-cut feeling by physicians that they must practice defensive medicine. Nevertheless, we are seeing a steady increase in both the numbers and the financial demands of such alleged malpractice suits.

We're still fighting the all-pervasive attitude that "something went wrong, therefore someone must have done something wrong." This is often fueled by physicians who will review in retrospect and determine that another course of action might have been more beneficial. They then erroneously conclude that this equates malpractice.

D.A. BAUMGARTNER, JR., MD
Cleveland

Psychiatrists not only ones who treat depression

To the Editor:

The National Mental Health Association's media blitz on depression, described in the April issue of *OHIO Medicine*, is a useful public service because people with this disorder need to be encouraged to seek treatment. Counseling and the appropriate use of antidepressant medicines are more effective in relieving depression than most people realize.

One part of your report was disturbing. The executive director of the Ohio Psychiatric Association was quoted as encouraging, without qualification, that depressed patients be referred to psychiatrists. However, family physicians are prepared in their residency programs to manage depressed patients skillfully, and that should be the case for other primary physicians as well. The psychiatrists with whom I have discussed the matter are unanimous in saying that primary physicians should learn to assess depressed patients, prescribe antidepressant medicines effectively, and provide supportive counseling for most of the people who present with depression in their practices.

ROBERT D. GILLETTE, MD
Youngstown

Kidney stones' underlying problem

To the Editor:

A few years ago, I saw a 65-year-old patient with a history of recurrent kidney stone disease. He claimed to have had 55 stones over the previous five years and had undergone three separate operations for stone removal. He came to see me to determine if there was any treatment that would reduce his kidney stone recurrence rate. When I checked with the hospital and his other physicians, I found out that there was absolutely no record of the chemical composition of this patient's stones!

This case illustrates how our concentration on the immediate therapy of existing stones, whether by surgery or ESWL, may cause us to overlook the underlying problems leading to recurrent stone production. Several excellent programs are commercially available for metabolic analysis of patients with kidney stone disease. At the current time, there is no excuse for not offering such a program to any patient with kidney stone disease who wishes to reduce the risk of a recurrence and is willing to follow treatment.

STEPHEN W. LESLIE, MD, FACS
Lorain

LETTERS TO THE EDITOR

Income verification not physicians' idea

To the Editor:

In the February 1993 issue of *OHIO Medicine*, you have a special section on Medicare billing under the new law enacted by HB 478. In that section, you have published a letter that we should have our patients sign in relation to disclosure of income. Would you please tell me why we should apologize for asking the patient's income? It isn't our doing – it's the government's.

When is organized medicine going to realize that the old standard of speaking softly and lobbying effectively is no longer working? Although (lobbying) should be continued and not abandoned, it is time to tell the public what is going on. We should say, "HB 478 mandates that you tell your physician your income." We shouldn't apologize for it! This is but one example of many things that should be told to the public – just one of many things that organized medicine isn't doing properly. For heaven's sake, start telling the people what's going on!

R.G. ROHMER, JR., MD
Columbus

Income verification one more intrusion

To the Editor:

Regarding the income verification letter put together by the OSMA and published in *OHIO Medicine*, I would like to make the following suggestion: I think it is imperative that we as physicians make the patients aware of the onerous nature of regulations and hassles, as that is the only way we are going to get patients behind us to develop an adequate political constituency to stop having laws and regulations done to us.

In keeping with that thought, I suggest that this income verification letter not include just the Medicare patient, as I do not think that House Bill 478 states that this need be the case for an income verification letter. Instead, I suggest that it be addressed to all patients and made a part of each physician's registration form at the front office, and that each patient be given this and asked to attest to it. I would strike out "Medicare" as an adjective. I would also add the descriptor of the law, namely House Bill 478, Balance Billing, in reference to it.

I would suggest then that each physician's registration form read as follows for the first paragraph: "In compliance with Ohio law (H.B. 478, Balance Billing), it is necessary for you as a patient to disclose to this office whether or not your annual income is above or below approximately \$40,000 per year. Under this new law, patients with incomes below this level must be billed differently." The rest of the letter could read as written.

I suggest this in the hopes that if enough people view this as an infringement of their privacy, which it is, that they would protest to their representatives. At the same time, our bringing this to their attention and pointing out that there is special treatment for individuals making less than \$40,000 per year, may get them wondering and more involved in the political process.

TIMOTHY J. FALLON, MD
Cleveland

OHIO Medicine welcomes letters to the editor. If you have an opinion you'd like to share, please write to: Editor, *OHIO Medicine*, 1500 Lake Shore Dr., Columbus, OH 43204-3824.

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More physicians choosing group practice

Ohio physicians, following a national trend, are increasingly moving from private practice into group practice settings. The OSMA, in response to that trend, is investigating how to improve service to group practice members.

Since 1965, the number of group practices nationally has increased by 286% and the number of physicians practicing in group settings has increased by 550%, according to new statistics released by the American Medical Association (see sidebar).

GROUP PRACTICES ON RISE

Originally, the thought was that group practices were attracting only the younger physicians who were opting for a more conventional lifestyle, one that allowed time for practicing medicine and time for a family life. However, as paperwork and hassle factors grow, physicians of all ages – including many older physicians – are being lured by the benefits group practices offer.

This trend toward group practices has caused the OSMA to re-examine its audience. "Although OSMA has traditionally focused on the individual physician in

Ohio Group Snapshot

- 32% of Ohio's physicians practice in group settings.
- There are 767 medical group practices in the state – up from 736 in 1988.
- The average size group is 10, although 53 groups in Ohio have 20 or more physicians.

solo practice, we now recognize that group practice physicians have particular needs that we must address," says Jill Foley, assistant director for group practice membership.

FOCUS GROUPS HELD

One step in addressing the issue of group practices was

taken in March when the OSMA hosted focus group discussions with group practice administrators and practicing physicians at a research facility in Columbus. The information garnered from the discussion will complement that already gathered through personal visits to many of the larger group practice facilities throughout the state.

The outcome of all the research has proved that administrators and physicians are in agreement that the OSMA needs to place more emphasis on group practices in the future. "OSMA is aware that the practice of medicine is changing, and part of that change appears to be a shift to a group practice environment," says Foley.

Comments from both administrators and practicing physicians will be examined more closely this month when the Group Practice Advisory Task Force, chaired by J. Craig Strafford, MD, of the Holzer Clinic, meets. ■

AMA-HMSS meeting planned

The AMA-HMSS has planned its 21st annual Assembly Meeting for June 10-14 in Chicago.

As reform of the American health-care delivery system is a pressing issue in the '90s, much of the meeting will be dedicated to studying this problem, including the following seminars:

"Negotiations and Conflict Resolution" – Meant to provide leadership in negotiating and resolving conflicts that arise in health-care delivery.

"Review and Analysis of President Clinton's Health-Care Reform Plan" – A review and analysis of the plan will be given by experts in the medical field.

"Challenge and Change in the Managed Care Environment" – Will present an overview of the health-care environment.

For information, contact the AMA at (312) 464-4754 or 464-4761. ■

OSMA In Action

A round-up of the association's activities...

Auxiliary wants Council vote

The OSMA House of Delegates will be asked to allow an OSMA Auxiliary representative who sits on Council (traditionally the auxiliary president) a vote at the Council table. The association's Constitution and Bylaws allows for a Council vote, but they limit auxiliaries' access to the floor of the House, since they are not full OSMA members. OSMA Auxiliary President Sara Rich says her group is interested in participating in Council decisions only and presently has no plans to request access to the House floor. The OSMA Council is sponsoring the resolution.

Legal Department expands staff

Welcome to Kate Sommers, who started in late March as legal assistant/paralegal, in the OSMA's Department of Legal Services. Sommers has three years experience working in various law firms, most recently at Reminger and Reminger in Columbus.

Medical students elect officers

At a recent meeting of the OSMA Medical Student Section members discussed student membership recruitment and also elected new officers. The new officers are: Tim Reeder, the Ohio State University School of Medicine, president; Randy Randolph, MCO Toledo, vice president; David Vensey, OSU School of Medicine, secretary; and

Andy Thomas, OSU School of Medicine, student alternate delegate to the Ohio AMA delegation. The new officers will serve a one-year term beginning immediately after the 1993 House of Delegates meeting.

Legislative bulletin mailed

The OSMA Department of Legislation has distributed the 1993 Ohio Legislative and Government Directory, which places the names, addresses and phone numbers of Ohio and U.S. senators and representatives at your fingertips. Seventeen-thousand directories were printed and mailed to OSMA members in March. If you are a member, and did not receive your copy and would like one, contact the OSMA Department of Legislation, 1-(800) 766-OSMA.

Health education curriculum discussed

Members of a task force to implement amended Resolution 38-92, dealing with health education in public schools, met recently and recommended that the OSMA staff survey county medical societies and obtain names of physicians and spouses who currently serve on local boards of education. Once the survey is complete, the task force would like *OHIO Medicine* to do a feature story that highlights a cross-section of physician/spouse school board members and their views on comprehensive health education. ■

CALENDAR

The OSMA has planned the following practice management workshops for 1993. Watch for more information on these workshops in future issues of *OHIO Medicine*.

Medical Office Management Institute (MOMI)

These workshops have been designed for medical office managers, supervisors and key employees. Some offices have used these workshops to upgrade the skills of established personnel as well as for indoctrination of new employees. The following five-day workshops can be taken in any combination:

- effective personnel management techniques;
- improving your managerial effectiveness;
- patient flow management;
- financial management;
- improving your third-party reimbursement and coding.

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Cleveland

August 2-6, Cincinnati
Kings Island Inn, Kings Island, Ohio

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Sept. 28 – Marriott Airport,
Cleveland

Sept. 29 – Concourse Hotel,
Columbus

Sept. 30 – Marriott, Cincinnati

IMGs share ideas at AMA forum

OSMA's International Medical Graduates Task Force Chair Woong S. Kim, MD, and Su-Pa Kang, MD, a member of both the task force and the AMA's IMG

Advisory Committee, traveled to Washington, D.C., recently for the AMA's fourth annual Advisory Committee on IMGs.

This two-day gathering of some

50 IMG representatives from county and state medical societies along with physicians from international backgrounds was an opportunity for members to share ideas and make suggestions on what concerns need to be addressed by IMGs. The large group



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broke down into smaller discussion groups which tackled such issues as licensure problems, discrimination, and special medical issues of concern to IMGs.

Fighting discrimination is just one of the OSMA's task force functions. Last year the task force began collecting anecdotal evi-

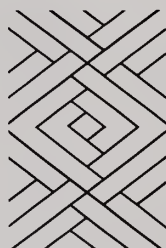
dence of discrimination to present to the AMA committee.

The Washington, D.C., location allowed attendees an opportunity to meet with their state representatives and senators. Dr. Kim met briefly with U.S. Rep. Paul E. Gillmor (R-Port Clinton) and his staff assistant to discuss health-

care issues and tort reform.

Since arriving home, the IMG Task Force members have been preparing a newsletter and planning a regional seminar for this summer.

OHIO Medicine will keep you posted on details about the summer conference. ■



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Second-Quarter Council Report

■ Legislative Report

OSMA Legislative Director John Van Doorn reports that the corrective bill on HB 478 has not yet been introduced at the Ohio Legislature, and he cautions that the changes it will make to the health-reform law will be minor.

He also reported that Ohio's certificate-of-need (CON) law expires later this year, and that the Legislature has created an advisory group to redraft CON law. OSMA Past President John Devany, MD serves as a member of this advisory group, representing physicians' interest.

■ State Medical Board

Ronald Agresta, MD, Steubenville, the new president of the Ohio State Medical Board, met with Councilors to explain the board's recent request to raise licensing fees. Dr. Agresta said the income it would recover from the increase would allow the board to fund a number of new programs. Dr. Agresta confirmed, however, that there were no guarantees that monies raised from the increase would go directly to the board.

The OSMA Council has taken the position that it would not support any fee increase greater than \$200 (see related story in the Legislative section).

■ Legal Report

Katrina English, director of OSMA's Department of Legal Services, said that the association is working with the Ohio State Medical Board to redraft some of the impairment rules governing impaired practitioners.

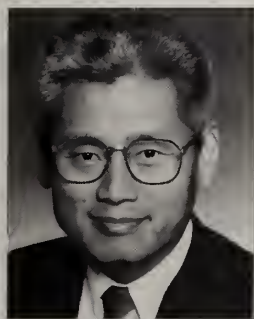
According to English, the former rules made some treatment providers uneasy about the way the board handles impairment cases. The new rules should take care of those problems.

Dr. Kang goes to Washington

By Su-Pa Kang, MD

Editor's note: A number of Ohio physicians went to Washington to attend the AMA's "Time for a New Partnership" forum – including OSMA President Stanley Lucas, MD. Dr. Kang sent us his impressions of that meeting.

The AMA organized a meeting, "A Time for a New Partnership" in Washington, D.C. on March 23-25. The AMA invited all physicians, regardless of their AMA membership status. I strongly felt that we should get involved in this important process, and arranged my schedule to attend.



Dr. Kang

I arrived at the Mayflower Hotel in Washington, D.C. on March 23, and was happy to find that there were over one thousand people from all over the country attending this meeting – more new faces than at any other AMA meeting I have attended. They came as individuals, and as county and state representatives. Twenty-seven people were from Ohio.

HIGH-PROFILE SPEAKERS

Ten of government's most powerful and high-profile politicians came to address us during the course of the conference. I can't recall any other time when this many high-caliber politicians came to speak at a meeting of organized medicine.

Both the Democrats and Republicans delivered the same message about health-care reform – that we need to cut down unnecessary paperwork, pursue tort reform and protect America's high quality of medicine. The bottom line is, people will be sick, regardless of how they change the

health-care system, and we must take care of the sick people.

That evening, forum attendees had a group dinner with their representatives and/or staff.

Each heard from physicians from their districts about medicine's views on health-care reform.

Thursday, we visited Capitol Hill for further discussion with our elected officials.

As health-reform is addressed in this country, physicians must speak in a unified voice about

what will be best for our patients. Let's not allow them to divide and conquer us. We should talk with our representatives, join the AMA and stay united. ■

Su-Pa Kang, MD, is a member of the OSMA's IMG Task Force.

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When do you "blow the whistle" on a colleague?

The practice of medicine, like all professions and occupations, includes members who behave unethically or incompetently. When a colleague acts inappropriately the decision to report that activity is fraught with many concerns. Will there be retaliation? Am I sure I saw what I think I saw? Could the actions have been misinterpreted? Do I want to turn in my friend? Will I gain a reputation as a whistle-blower?

Although the answers to many of these questions may be uncomfortable, physicians are obligated both morally and ethically to "snitch" on their colleagues. The practice of medicine is unique because doctors who practice inappropriately can damage the health and well-being of their patients. Therefore, the reporting obligations placed on physicians are significant.

ETHICAL OBLIGATIONS

Medical ethics have always required doctors to police their own. The preamble to the AMA's Principles of Medical Ethics says that the ethical statements of the medical profession were developed primarily for the benefit of patients. Physicians are ethically responsible to patients, society, other health professionals and themselves. This means that doctors must be willing to blow the whistle on their colleagues. The Principles of Medical Ethics

Violations that must be reported include any violation of the grounds for discipline contained in ORC 4731.22, such as:

- (2) Failure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;
- (3) Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes;

specifically states: "A physician shall ...strive to expose those physicians deficient in character or competence, or who engage in fraud or deception" (emphasis ours). When aware of behavior that is inappropriate doctors should report to hospital peer review committees, county medical societies or any other entity that has authority to confront and potentially resolve the problem.

LEGAL OBLIGATIONS

Add to this the medical board's mandatory reporting requirements and you end up with both an ethical and legal obligation to report colleagues who act inappropriately. The Ohio medical practices act legally requires physicians to report any belief that a violation of the medical practices

Violations Requiring Reporting

- (6) A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances;
- (8) The obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;
- (17) Any division of fees or charges, or any agreement or arrangement to share fees or charges...with any other person so licensed or with any other person;
- (18) The violation of any provision of a code of ethics of a national professional organization.
- (19) Inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness;
- (26) Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice.

act has occurred. The board adopted rules that became effective in 1991 to clarify the duty to report. Violations of the medical practices act or any rules of the medical board must be reported (see related story). Suspicion alone is not sufficient to require reporting. A physician's individual subjective belief triggers the mandatory reporting requirement. Hospitals, surgical centers, professional liability insurers and professional societies are also required to report to the medical board.

Physicians who learn of a violation through service on a peer review committee are exempt from the reporting requirement. There is also a specific exemption for approved impaired physician treatment providers, as well as any member of a hospital or

professional society impaired physician committee if two conditions are met: 1) the impaired physician cooperates with referral for examination and any determination that he/she should enter treatment and 2) there is no reason to believe that the impaired physician has ceased to participate in the treatment program.

DOCTORS SHOULD BE WILLING TO BLOW THE WHISTLE

The bottom line is that doctors should report unethical or illegal behavior of their colleagues. Reporting will maintain the integrity and quality of the profession. At a time when doctors need to do all they can to bolster their public image, the act of self-policing can send a very positive message to consumers. ■

Data bank management criticized

The National Practitioner Data Bank has come under fire from the U.S. General Accounting Office (GAO) for poor management.

In a recently released report the GAO says that the Department of Health and Human Services (HHS) has allowed weaknesses in management to undermine the data bank's

achievement of a timely, secure and cost-efficient operation.

The GAO cited the following specific faults:

- Questions asked by users go unanswered for several weeks, which in turn delays the granting of privileges to health-care practitioners.
- On occasion sensitive practi-

tioner data has been given to organizations not entitled to receive such data.

- The data bank contractor has been inadequately monitored, thus allowing known automated problems to persist.

The report also stated that HHS plans to redesign the bank, but that plans haven't incorporated a sound system develop-

ment approach because of funding uncertainties. Thus, the redesigned system may still be flawed and inefficient.

The data bank was established by the Health Care Quality Improvement Act of 1986. It contains information on adverse actions taken against the licenses, clinical privileges and professional society memberships of physicians, dentists and other health-care practitioners. ■

Read this before buying a "Yellow Pages" ad

This is the time of year when sales representatives appear in your office soliciting advertising for the "Yellow Pages," but before you commit your money, you would be wise to determine exactly where your ad will appear.

A number of companies these days produce telephone directories, and all seem to have their own version of the "Yellow Pages." It's easy to become confused. Without checking, however, you may find your ad in a directory aimed at a broad consumer market rather than in your local business telephone book where it is likely to produce better results.

Here are a few tips to keep in mind before you buy your Yellow Pages advertising:

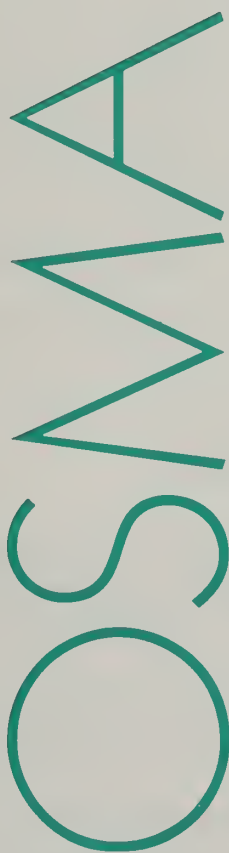
- There are two major telephone companies in Ohio, and each produces its own Yellow Pages. Ohio Bell publishes the Ameritech Yellow Pages and General Telephone produces the GTE Directory.
- Sales representatives from both of these companies will clearly identify themselves when soliciting advertisements. If you are unsure of a solicitor, you may call the number that is listed in the front of each of the Yellow Pages directories listed above. The number will be found under the heading "Advertising - Directories."
- Both of the two major phone companies will first contact the customer, collect the appropriate information, then send the customer a contract, accompanied by a cover letter on company letterhead. Renewal of an advertisement is done in a similar manner. The customer is sent a contract with a cover letter. Neither company will ask you to first submit payment in order to enroll as an advertiser.
- Company logos, like the "walking fingers," are not necessarily trademarked, so don't assume that when you

see such logos, you are dealing with either of the major phone companies. (General Telephone, however, does incorporate its company's acronym "GTE" with

the "walking fingers" symbol.)

In summary, then, to avoid confusion when you buy a listing in the Yellow Pages, ask representatives to identify themselves,

and ask for a business card when possible. If necessary, check the local listings for the publisher of the phone book and verify the validity of the solicitation. Finally, don't send any money until you are certain where your ad will appear. ■



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New board program increases access to license information

In Brief: The Ohio State Medical Board recently unveiled a new program that claims to shorten the turnaround time on license verification requests.

Information regarding your medical license – including reports of any disciplinary action taken against you – may become easier to obtain.

The Physician License Access Network (PLAN), a new on-line computer system developed by the Ohio State Medical Board and unveiled, for the first time, at the OSMA's Leadership Conference in March, promises users faster turnaround time on their license verification requests.

According to Joan Wehrle, public inquiries officer for the board, hospitals, managed-care programs, county medical societies and others who enroll as PLAN

users will be given a confidential access number by the board, which will allow them to select the information they need from a set menu. There are certain safeguards to retrieval of this information, however.

"The access code provided a user will also control how much information that user can obtain," explains Wehrle.

Generally, however, users will be able to determine whether or not a practitioner is currently licensed in Ohio, and whether or not any disciplinary action has been taken against the licensee. Authorized users permitted by the state to have access to the board's mandatory reporting information may also access this information through PLAN.

The board hopes that PLAN will shorten the time between requests for information and



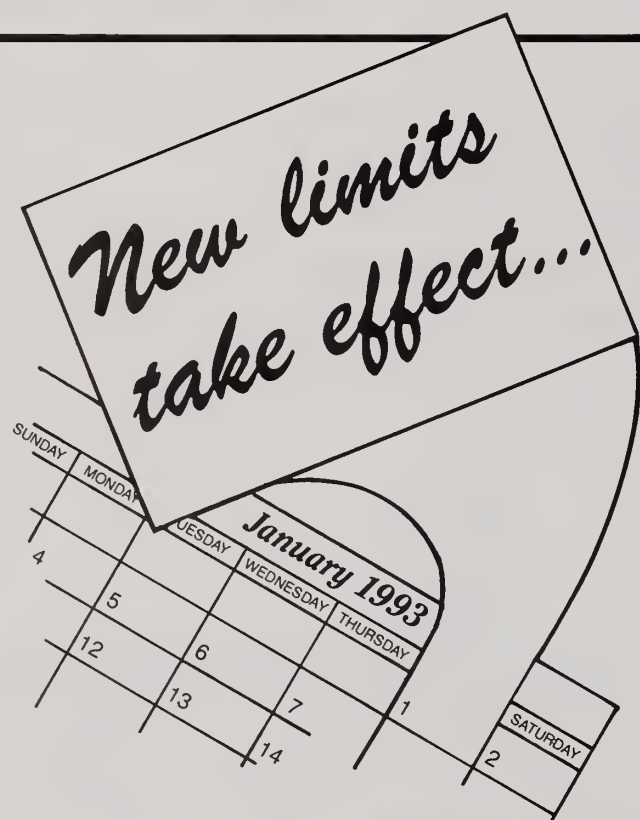
Joan Wehrle, medical board public inquiries officer, explains the board's new computer system at the OSMA's recent Leadership Day.

delivery – a process that has, in the past, slowed considerably, as board staff attempted to handle, on their own, the approximately 48,000 license verification requests the board receives each year.

While fees for users of the new system are still under negotiation,

Wehrle says the amount will most likely be under that of the National Practitioner Data Bank.

For more information about the program, contact Joan Wehrle, public inquiries division, the Ohio State Medical Board, 77 S. High Street, Columbus, OH 43266-0315, (614) 466-3934. ■



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Tips on avoiding an OSHA inspection

Despite the recent articles in *OHIO Medicine* about Ohio physicians fined large amounts of money by OSHA, the agency does not appear to be on a witch hunt, randomly targeting offices for inspections.

"Statistics on investigations indicate that OSHA is responding to complaints, and is not specifically targeting doctors' offices for random checks," says Katrina English, JD, director of OSMA's Department of Legal Services.

She offers the following tips to physicians as things they can do to keep a complaint from coming out of their practices:

- **Educate employees** – Disgruntled employees are the primary source of initiating investigations. Doctor should make their OSHA compliance measures clear to all employees.
- **Educate yourself** – Doctors are not always clear about the hazardous communications requirements. Many physicians believe, for example, that the blood-borne pathogen regulations are the only

provisions that apply to them.

They are not. To receive information about all of the OSHA

regulations applicable to physicians, contact the OSMA Department of Legal Services.

OSHA penalties and citations can be challenged. Some doctors have had success in reducing both penalties and fine amounts. Legal counsel can assist you in

these negotiations with OSHA.

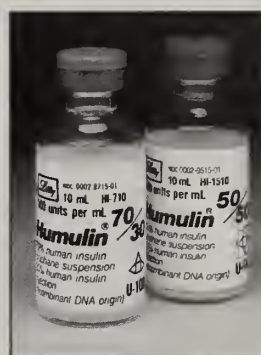
If you have any questions about these points, or need further information on the OSHA regulations, contact the OSMA's Department of Legal Services, 1-(800) 766-OSMA. ■




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Update

Defining expert opinion

Expert testimony should be limited to opinions founded in scientific knowledge or based on valid scientific methodology, says the AMA in a friend-of-the-court brief filed recently before the U.S. Supreme Court in the case of *Daubert v. Merrell Dow Pharmaceuticals*.

The Daubert case involves expert testimony, allegedly without scientific basis, that has been used in product-liability suits to link the morning sickness drug Bendectin to birth defects.

The outcome of the case will most likely determine the legal role of medical expert testimony in the future.

OSMA's Up-And-Coming Movers And Shakers

A Look at Some of the Association's Outstanding Young Physicians

Editor's Note: Talk about difficult! When *OHIO Medicine* asked OSMA leadership and staff to submit names for a list of young "movers and shakers," we were planning a short article on future leaders. But the response was overwhelming. So overwhelming in fact, that we found ourselves with enough candidates to fill an entire issue. So instead, we selected 11 young physicians for this issue and will continue to highlight other nominees in future issues. The question for these physicians is: "What role will organized medicine play in the future?"

Mary Kay Smith, MD
Toledo
Psychiatry

- Medical College of Ohio, 1991
- Ohio Psychiatric Association, chair, members-in-training committee
- Recipient of the American Psychiatric Association's William Sorum Award



"The nation faces a major crisis in health care that necessitates reform at all levels. Professional organizations, such as the American Psychiatric Association, the Ohio Psychiatric Association and the OSMA, must play a key role in this process. The policies that are formulated will affect the well-being of the American people for decades to come, and we must seize this opportunity to ensure that our professional societies serve as effective advocates for physicians and patients alike."

Ron A. Zile, MD
Hillsboro
Family Practice

- Wright State University School of Medicine, 1988
- Co-president, Highland County Medical Society
- OSMA Delegate
- Medical adviser, Highland County Unit of the American Cancer Society



"As a young solo practitioner in a small rural community, I am constantly challenged by the ever-changing health-care environment. Fortunately organized medicine will provide a vehicle by which I can effectively influence change at the county, state and national levels. This affords me the opportunity to continue to provide quality health care to my patients while maintaining a reasonable working and professional environment for my colleagues and me."

Deborah A. Geer, MD
Wilmington
General Surgery

- University of Rochester Medical School, 1981
- Former Army major
- Vice President, Clinton County Medical Society
- Ohio delegate to AMA's Young Physicians' Section



"Organized medicine will play a more important role than ever before. We are facing a crisis in health-care costs which must be addressed, but the needs of our patients must remain the highest priority. Only through organized medicine can we, as physicians, hope to achieve these goals. Only physicians are going to place patients as the priority in health-care reform. Acting as one body will be our only avenue to success, as we pursue, along with government, the issue of health-care reform."

James Augustine, MD
Dayton
Emergency Medicine

- Wright State University School of Medicine, 1983
- Chair, State Board of Emergency Medical Services
- Board of Directors, Ohio Chapter, American College of Emergency Physicians



"Organized medicine's role, now and in the future, is to provide a level playing field for physicians to practice their art and provide the best medical care that they are capable of giving."

Denise L. Bobovnyik, MD
Boardman
Family Medicine

- Northeastern Ohio Universities College of Medicine, 1985
- OSMA Delegate, 1991
- Chair, OSMA's Young Physician's Committee
- Member, Mahoning County Medical Society Council



"I see organized medicine becoming stronger and more effective. The present political climate has given organized medicine legitimacy in the eyes of the clinical physician. It's the main mechanism for us to be heard as a collective voice."

Ronna L. Staley, MD
Richfield
Pediatrics

- University of Cincinnati College of Medicine, 1980
- Council member, Summit County Medical Society
- OSMA Alternate Delegate
- Past president, Akron Chapter, American Medical Women's Association



"I see organized medicine continuing its representation of patients and physicians before the courts and legislatures as our country advances through health-care reform. While this effort will dramatically impact the future of our nation, organized medicine will provide the strongest collective, physician-directed voice. I view this as the greatest challenge for the AMA, state and county medical societies in the future."

Margaret M. Dunn, MD
Dayton
Surgery

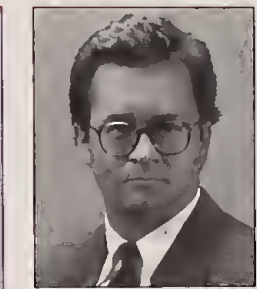
- Jefferson Medical College, 1977
- Vice president, Ohio Chapter, American College of Surgeons
- Past president, Dayton Surgical Society
- Recipient, Wright State University's Excellence in Medical Education Award



"The ability of a single physician to shape the forces determining our ability to prevent and treat disease is vanishing quickly. Only by concordant action on behalf of our patients and our colleagues can we hope to influence the future health-care environment in this nation. Despite the challenges ahead, medicine will remain a uniquely satisfying profession. To best care for all of our citizens, we must seek to attract and nurture students to medicine who affect the richness and pluralism of American society."

Emil Mitchel Opremcak, MD
Columbus
Ophthalmology

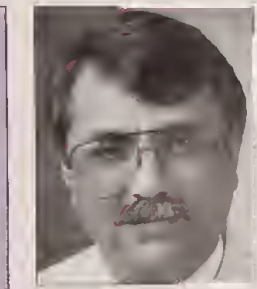
- Ohio State University College of Medicine, 1981
- Chair, Ohio Ophthalmologic Society's Legislative Committee
- OSMA Committee on State Legislation
- Board of Directors, National Society to Prevent Blindness



"I see four areas in which organized medicine will play a role in the future: 1) organized medicine needs to continue to sponsor medical education programs; 2) organized medicine needs to continue its proactive political action; 3) organized medicine should become more involved in sponsoring medical research; and 4) organized medicine should take a more active role in being a patient advocate, perhaps even to the extent of including patients on committees and boards."

Tariq A. Siddiqi, MD
Cincinnati
Perinatal Medicine

- King Edward Medical College, 1975
- Member, OSMA's International Medical Graduate Task Force
- Member, Association of Pakistani Physicians of North America
- Member, Perinatal Reserach Society



"Physicians must assert their function as leaders in medicine and health-care reform. We must attain leadership in organized medicine, now and in the future, ensuring that as health-care providers, we are in the vanguard concerning health-care policy. We must continue to be the decision-makers and not allow ourselves and our profession to be led by bureaucrats."

Patrick W. McCormick, MD
Toledo
Neurological Surgery

- University of Cincinnati College of Medicine, 1984
- Co-chair, OSMA's Bureau of Workers' Comp committee
- Member, American Heart Association's Stroke Council, American Association of Neurologic Surgeons



"In the near term, it's obvious there will be tremendous changes in the organizational structure of medical care reimbursement, provider organizations and regulatory policy. This change is being brought about by a political climate fueled by popular opinion. Physicians have been identified as part of a problem, and they have not been considered stakeholders in determining future directions for solving these problems. I see organized medicine as the only viable and practical option for physicians who want to influence the course of this change to protect the quality of the care they deliver and the system they work within."

James M. Sudimack, MD
Warren
Emergency Medicine

- Ohio State University College of Medicine, 1984
- OSMA Delegate; AMA Delegate to Young Physicians Section
- Past President, Trumbull County Medical Society
- Chair, OSMA's Young Physicians Committee



"Fortunately, Hillary Clinton unintentionally helped organized medicine by declaring that it should not be involved in discussions to determine the future course of health care, because that would be a 'conflict of interest.' I believe attitudes like this will motivate physicians to become involved in organized medicine, and that this will give professional societies more leverage and credibility when dealing with legislative bodies. Clearly, it's in the role of patient advocate that organized medicine will need to be more active and aggressive in the near future. Success or failure in this area will determine the long-term role and viability of our medical organizations."

Highlights of the 8th international conference on AIDS

By Michael F. Para, MD

KAPOSI'S SARCOMA

Dr. Robert Gallo presented his laboratory's work on this tumor.

Kaposi's sarcoma is identified by the presence of spindle-shaped cells that are not truly cancerous. He believes these are non-malignant immature cells originating

from the blood vessels. They occur normally with injury and then are supposed to mature into normal cells. However, the HIV protein, TAT, stimulates these

spindle cells to multiply in their immature state. The increasing number of spindle cells then promotes the growth of even more spindle cells and a "tumor" develops. Work is now proceeding on how to block the stimulation of the spindle cells by the TAT protein. This could replace the use of chemotherapy to eradicate these cells.

TRANSMISSION

There continues to be increasing evidence that all sexually transmitted diseases (STDs) increase the risk of HIV transmission by three- to five-fold. There had previously been good evidence that STDs causing open sores, such as syphilis, did this, but now nonulcerating STDs, such as gonorrhea and trichomonas, have been implicated as increasing transmission. This is even more serious since it also appears that HIV makes STDs harder to cure, and more infectious. This cycle makes the control of all STDs, not just HIV, very important. Two investigators found the AIDS virus (HIV) is present in the pre-ejaculatory fluid of HIV infected men. This suggests that this fluid could transmit the virus.

A study from Zambia, examining the heterosexual couples who at study entry were discordant for HIV (one +, one -), showed that a couple who always used condoms had a very low rate of transmission. Further, if it was the man who was HIV infected, and his partner used a spermicide, there was a moderate degree of protection against infection in the women. A number of other studies confirmed the effectiveness of condoms in reducing transmission.

Michael F. Para, MD is an infectious disease specialist at Ohio State University Hospitals in Columbus. He has been named co-chair of a national group of healthcare professionals that will review, approve and monitor new approaches to HIV therapies. OHIO Medicine will periodically publish his notes from the International AIDS Conference, held last year. ■

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Donald Kling
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Gary LaGasse
Dayton, Ohio



Keith Nelson
Columbus, Ohio

Red Cross says blood supply safe

How safe is Ohio's blood supply? American Red Cross Blood Services, central Ohio region, has issued a fact sheet for physicians on the safety of the blood supply as of March.

According to the Red Cross literature, there have been no documented cases of transfusion-associated HIV/AIDS linked to

central Ohio's tested blood supply since April 1985, when HIV testing of the blood supply began.

The fact sheet also discusses autologous blood and directed donation opportunities, although Ambrose T. Ng, MD, principal

officer of the American Red Cross Blood Services in central Ohio, is quick to add that the "community supply is adequate, available, reliable and safer than ever before."

For more information on securing the fact sheet or for

information on the safety of the blood supply, contact Communications, American Red Cross Blood Services, Central Ohio Region, 995 E. Broad St., Columbus, OH 43205, (614) 253-7981, ext. 275. ■

Pollen count hotline available

Need a pollen count? Doctors in the Cleveland area can once again take advantage of the free pollen-count hotline, sponsored by the Cleveland Academy of Medicine and the Cleveland Allergy Society.

Allergist Parrish Garver, MD, will provide recorded telephone reports on the density of pollens in the environment from April 15 to October 15. The report will reflect a 24-hour sample.

"This year, due to the extremely cold weather and an extended winter season, the pollen season will begin later, resulting in a higher pollen count and stronger symptoms," says Dr. Garver.

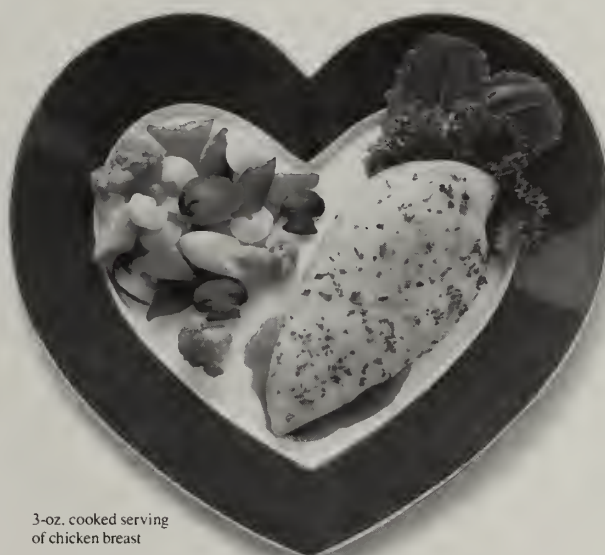
Physicians and the public can call the free hotline 24 hours. The number is (216) 231-7484. ■

Ohio sets up SIDS hotline

Facts and advice about sudden infant death syndrome (SIDS) as well as referrals to support groups throughout the state are now available to patients and health professionals via the new SIDS hotline. The network has been developed by the Ohio Department of Health and the SIDS Alliance.

SIDS accounts for approximately 250-300 infant deaths in Ohio each year. The hotline number is 1-(800) 477-SIDS (7437). ■

Breast of chicken



3-oz. cooked serving of chicken breast

Best of pork



3-oz. cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

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Compare pork with chicken^{1,2*}

| | Calories | Total Fat | Saturated Fatty Acids | Cholesterol |
|---|----------|-----------|-----------------------|-------------|
| Chicken Breast, skinless | 140 | 3.0 g | 0.9 g | 72 mg |
| Pork Tenderloin, trimmed | 139 | 4.1 g | 1.4 g | 67 mg |
| Pork Top Loin Roast (boneless), trimmed | 165 | 6.1 g | 2.2 g | 66 mg |
| Center Loin Chop, trimmed | 172 | 6.9 g | 2.5 g | 70 mg |
| Chicken Thigh, skinless | 178 | 9.2 g | 2.6 g | 81 mg |

*Table refers to 3-oz. cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.¹ According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.¹

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.

2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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BITUARIES

ALBERT I. ARONOFF, MD, Cincinnati; University of Cincinnati College of Medicine, 1942; age 76; died January 24, 1993; member OSMA.

JOHN R. BROWN, MD, Ottawa; Ohio State University College of Medicine, 1957; age 67; died December 2, 1992; member OSMA.

EMERY J. BRAUN, MD, Akron; Ohio State University College of Medicine, 1935; age 83; died January 27, 1993; member OSMA and AMA.

DANIEL S. BUNNER, MD, Columbus; Ohio State University College of Medicine, 1934; age 83; died January 29, 1993; member OSMA and AMA.

EDWARD R. CERUTTI, MD, Cleveland; Facultad de Ciencias Medicina de la Universidad de Buenos Aires, Argentina, 1950; age 69; died February 27, 1993; member OSMA and AMA.

THOMAS E. CLARK, MD, Columbus; Ohio State University College of Medicine, 1940; age 78; died February 9, 1993; member OSMA and AMA.

RICHARD DeNISE, DO, Cleveland; Philadelphia College of Osteopathic Medicine, Philadelphia, PA, 1942; age 73; died February 18, 1993; member OSMA.

FRANCIS W. GALLAGHER, MD, Columbus; Ohio State University College of Medicine, 1940; age 78; died January 11, 1993; member OSMA and AMA.

NATHAN KALB, MD, Lima; Eclectice Medical College, Cincinnati, 1937; age 83; died February 19, 1993; member OSMA and AMA.

RICHARD E. LANDIS, MD, Cincinnati; University of Cincinnati College of Medicine, 1954; age 63; died December 16, 1992;

member OSMA and AMA.

MAX LESY, MD, Beachwood; School of Physic, Trinity College, University of Dublin, Dublin, Ireland, 1937; age 93; died February 17, 1993; member OSMA and AMA.

GEORGE W. MARKUS, MD, Dayton; Loyola University Stritch School of Medicine, Maywood, IL, 1947; age 70; died February 12, 1993; member OSMA and AMA.

CHARLES W. MOCKBEE, MD, Cincinnati; Tulane University School of Medicine, New Orleans, LA, 1944; age 73; died December 4, 1992; member OSMA and AMA.

JANET ORTTUNG-MORROW, MD, Columbus; University of Pennsylvania School of Medicine, Philadelphia, PA, 1962; age 55; died January 22, 1993; member OSMA.

THEODORE A. PUSKAR, JR.,

MD, Akron; Loyola University Stritch School of Medicine, Maywood, IL, 1955; age 63; died February 16, 1993; member OSMA and AMA.

WILLIAM C. ROCHE, MD, Gnadenhutten; Ohio State University College of Medicine, 1925; age 93; died February 1, 1993; member OSMA and AMA.

LEWIS A. SCHMIDT III, MD, Gallipolis; Vanderbilt University School of Medicine, Nashville, TN, 1952; age 65; died February 6, 1993; member OSMA and AMA.

JULIUS M. TESI, MD, Buckeye Lake; Ohio State University College of Medicine, 1948; age 74; died February 2, 1993; member OSMA.

ROBERT W. WOLIUNG, MD, Cincinnati; University of Cincinnati College of Medicine, 1943; age 73; died February 1, 1993; member OSMA and AMA. ■



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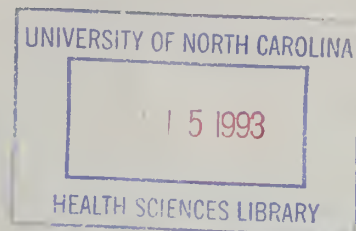
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OHIO *Medicine*



News for Members of the Ohio State Medical Association

Delegates meet in Cleveland Annual Meeting proceeds smoothly

In Brief: There was little dissension at this year's meeting, perhaps an indication of medicine's intention to close ranks and stay united.

Resolutions were adopted, amended and rejected without much fanfare at the final session of the OSMA House of Delegates' 1993 Annual Meeting, held May 14-16 in Cleveland.

Delegates, for the most part, were satisfied with the work of the three resolutions committees that heard testimony, sometimes passionate, all day Saturday, prior to the final session of the House on Sunday.

The resolutions this year seemed to reflect the profession's increasing frustration with encroaching government regulation, interference from third parties, and the rapidly expanding scope of allied practitioners. Yet no one resolution surfaced as the year's "hot issue," nor did any seem to excite the kind

See **MEETING** page 2

Photo by Diana McNees



Dr. Reiling Installed

Walter A. Reiling Jr., MD, Dayton, right, is installed as president of the OSMA by Past President Joseph Sudimack, Jr., MD, as Dr. Reiling's wife, Suzanne, looks on. He assumed the office from outgoing President Stanley J. Lucas, MD, Cincinnati, at the association's Annual Meeting, held May 14-16 in Cleveland.

Surgeons due retro pay OSMA complaints to BWC

In Brief: OSMA convinced HCFA that many Ohio physicians are due back pay for laparoscopic cholecystectomies that have been insufficiently reimbursed by Medicare.

Surgeons who performed laparoscopic cholecystectomies (CPT codes 49310 and 49311) in the last 18 months may be entitled to a hefty reimbursement from Nationwide-Medicare.

As a result of a very active campaign by

the OSMA, hundreds of Ohio physicians are eligible to receive thousands of dollars in reimbursement from procedures that were insufficiently paid by Medicare.

The OSMA has been seeking this retroactive reimbursement since the implementation of the Medicare RBRVS in January 1992, which resulted in an almost 50% reduction in reimbursement for laparoscopic cholecystectomies. "We've attempted on several occasions to rectify this situation, but until recently could not find the key to do so," says William Fry, director of the OSMA Department of Ombudsman Services.

However, in March, the OSMA learned that New York Medicare (Empire Blue Cross Blue Shield) had been ordered by the Health

The OSMA has sent a strongly worded complaint to the Ohio Bureau of Workers' Compensation (BWC) regarding the fee reduction implemented by BWC in early April. As of press time, OSMA had not received a response from BWC.

The letter put on record OSMA's opposition to the new UCR fee reduction schedule and the fact that BWC significantly lowered its reimbursement level without physician input or adequate notice to physicians.

The OSMA also expressed anger over the fact that BWC purchased the new fee schedule, modeled after a managed care rather than a

Inside

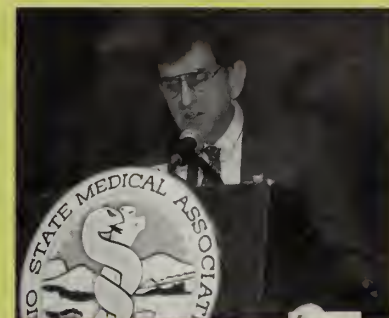
■ HEALTH-CARE REFORM:

This new feature will regularly update physicians on what's new in health-care reform at the national and state level, as well as at the OSMA. 8

■ SRF LETTERS SENT:

Notification letters and claim forms have been sent by the Stabilization Reserve Fund. Here are answers to questions about how to claim a refund. 13

■ **CLIA QUESTIONS:** What type of CLIA certificate do physicians need? What are the waived tests? OSMA's Ombudsman staff answers often-asked questions about CLIA '88. 21



Outgoing president, Dr. Lucas

■ **ANNUAL MEETING:** The ceremonies, events and faces of this year's Annual Meeting are captured in photographs. 28

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of heated debate that has marked previous meetings. If nothing else, this year's lack of controversy might be the best indicator, yet, of organized medicine's intention to

Government regulations continue to frustrate OSMA delegates.

close ranks and stay united in the face of the health-care reform measures to come.

STATEWIDE FEE A GOOD EXAMPLE

Resolution 14-93 may be the best example of this.

The resolution grew from a year-long dispute between rural physicians, who want the government to implement an early statewide Medicare fee schedule, and urban

physicians who do not.

Testimony during committee hearings was surprisingly minimal on this issue, and no comment was made on the House floor when a recommendation rejecting the resolution's proposed lawsuit for a uniform schedule came up for a vote.

On the other hand, resolutions committee number three heard a number of impassioned testimony from delegates who were frustrated by what they view as a lack of personal rights under administrative law – the kind that's dealt by OSHA, CLIA and other governmental agencies. The committee's recommendation to refer the matter to Council for study was hastily adopted by the House.

OHIO Medicine will be closely following a number of the issues that were presented at this year's Annual Meeting. Watch future issues of *OHIO Medicine* for more news on these matters. (See photo spread of Annual Meeting on pages 28-29.) ■

Dr. Wolfe voted OSMA president-elect

Claire Wolfe, MD, who ran unopposed for the office of OSMA president-elect, was officially voted into that



Claire V. Wolfe, MD

position on Sunday, May 16, at the final session of the OSMA Annual Meeting. Dr. Wolfe will be the first woman president of the OSMA. She will take office in May 1994.

Other election results are below:

Councilors

Second District: Stephen T. House, MD

Fourth District: Su-Pa Kang, MD

Sixth District: David J. Utlak, MD

Eighth District: Thomas J. Hall, MD

Tenth District: Mary Jo Welker, MD

Twelfth District: Charles A. Peter, MD

Delegates to the AMA, Jan. 1, 1994-Dec. 31, 1995

Donavin A. Baumgartner, Jr., MD

John A. Devany, MD

William J. Marshall, MD

Joseph Sudimack, Jr., MD

Lee J. Vesper, MD

Claire V. Wolfe, MD

Alternate Delegates, Jan. 1, 1994-Dec. 31, 1995

(Due to a constitutional technicality, six instead of seven alternates were elected, with the medical students retaining a one-year seat that was voted on in March.)

Owen E. Johnson, MD

Walter E. Matern, MD

Ronald L. Price, MD

Jack L. Summers, MD

David J. Utlak, MD

Lance Talmage, MD ■

UCR schedule, from an outside consulting firm, without any consultation from the medical community. The managed care schedule is the lowest fee schedule used by Medirisk, the contracting agent hired by BWC to establish an Ohio UCR system.

The OSMA also is concerned because it has been unable to obtain a copy of the new fee schedule from BWC. The OSMA has repeatedly requested a copy of the

full fee schedule. When the suggestion was broached previously, BWC officials said that Medirisk would not allow such data to be disclosed.

The OSMA Task Force on Workers' Compensation, which has followed this issue closely, will continue to review options to address the problems raised by the new fee schedule. *OHIO Medicine* will keep you updated. (See the related story on page 5.) ■

SURGEONS...*From page 1*

Care Financing Administration (HCFA) to correct its low reimbursement levels for laparoscopic cholecystectomies. These corrections, in some cases, amounted to 100% increases in reimbursement. Hoping to gain from the New York experience, the OSMA immediately petitioned the HCFA office in Chicago to review Ohio.

SUSPICIONS CONFIRMED

HCFA confirmed OSMA's suspicions that the state's physicians performing laparoscopic cholecystectomies for Medicare patients since January 1992 were paid insufficiently and were due refunds. As a result, some Ohio physicians will receive double the amount of reimbursement originally received for the procedure.

Some doctors will receive double their original reimbursement.

For surgeons performing several laparoscopic cholecystectomies per week, the reimbursement should be substantial.

Earlier in the year OSMA discussed the discrepancies with representatives of Medicare and were assured at that time that Ohio Medicare correctly reduced these procedures directly to the 1996 fee schedule levels, because without historical payment data, Medicare was not required to transition gradually into the fee schedule. Medicare said it was simply following HCFA's directives.

Whether the reimbursement for a particular service was transitioned

over the five-year period or moved directly to the fee schedule was determined by comparing the 1992 fee schedule amount to the Historical Payment Base (HPB). If the difference between these amounts was greater than 15%, the reimbursement level was transitioned. In the case of laparoscopic cholecystectomy, the amount was greater than 15% and should have been transitioned over the five-year period.

MEDICARE REOPENS CLAIMS

When the issue was first raised by Ohio physicians, HCFA contended that setting the reimbursement for these codes at the fee schedule amount without any transition was correct. After further review, prompted by the OSMA, HCFA advised Nationwide-Medicare to recalculate and reopen all claims for the calendar year 1992 through May 10, 1993. Claims will be adjusted after Medicare receives a request from the physician.

To file for amended reimbursement, physicians with assigned claims billed incorrectly must bundle copies of their Explanation of Medical Benefits (EOMBs), highlight the claims to be reopened and include a cover letter requesting review and reopening to Nationwide-Medicare, Claims Operations, Attn: J. Bevens, P.O. Box 182195, Columbus, OH 43216. An amended claim must be filed for all nonassigned claims, where the limiting charge reported was lower than the new allowed limiting charge amount. These claims are also bundled with a cover letter and sent to the Medicare address.

Contact the OSMA Ombudsman if you need assistance. (See the related chart on fee schedule amounts on page 24.) ■

1993 House of Delegates – Actions on Resolutions

| Resolution # and Name | Referred to Council | Adopted | Rejected | Resolution # and Name | Referred to Council | Adopted | Rejected |
|--|---------------------|---------|----------|---|---------------------|---------|----------|
| OSMA | | | | 48. Changing the Current Political System | | | CC |
| 1. Commendation – Carol Maddy | | CC | | 53. Administrative Law | ✓ | | |
| 2. Davis' Rules of Order | | CC | | 54. Administrative Law #2 | ✓ | | |
| 3. Medical Student Representative on the Ohio Delegation to the AMA | | A, ✓ | | 55. Repealing of Federal and State Administrative Law | ✓ | | |
| 4. OSMA Auxiliary Representative Vote | | A, ✓ | | 56. Administrative Law | | A, ✓ | |
| 5. Reorganization of AMA Delegation | | | ✓ | Health-Care Reform | | | |
| 6. Restore Voting Rights to OSMA Members | | | CC | 20. Private Sector Proposal for Part B Medicare | CC | | |
| 7. Negotiations by OSMA for Its Members ² | | ✓ | | 22. Medicaid Reform | ✓ | | |
| 9. Dues Reduction for Certain Physicians | | | ✓ | 25. Medicaid Vouchers | ✓ | | |
| 10. Relocation of Annual Meeting | | | ✓ | 32. Physician Exclusion Criteria – Health-Care Plans | ✓ | | |
| 19. OSMA Endorsement Income | | | ✓ | 33. Stipulation for Health-Care Reform I | ✓ | | |
| 67. Use of Recyclable Paper for Medical Publications | | ✓ | | 34. Stipulation for Health-Care Reform II ³ | | ✓ | |
| 71. Ohio Medical Hall of Fame | | A, ✓ | | 36. Prohibition on Medicare Balance Billing ⁴ | | ✓ | |
| Discipline/Review | | | | 42. Physician Fees and the Uninsured Patient | ✓ | | |
| 51. State Medical Board ⁶ | | ✓ | | 43. Fee for Service | | A, ✓ | |
| Ethics | | | | 44. True Health Insurance and a Fair, Equitable Approach to Payment of Premiums | ✓ | | |
| 40. Confidentiality | | ✓ | | 45. Repeal of the Law that Allows Health Insurance Premiums To Be Non-Taxable | ✓ | | |
| 74. Establishment of a Commission for Effective and Efficient Use of Resources | ✓ | | | 46. H.B. 478 – Overcharging Provision | ✓ | | |
| 75. Biomedical Research | | A, ✓ | | 49. Repeal of the McCarran-Ferguson Act ⁵ | | ✓ | |
| 76. HIV-Positive Immigrants | | A, ✓ | | 57. Preservation of Patient/Physician Relationship | | A, ✓ | |
| Government Reform | | | | 58. Contracts Between Managed-Care Plans and Participating Physicians | ✓ | | |
| 21. Medical Care in Nursing Homes | | A, ✓ | | | | | |
| 26. Timely Transfer of Patients to ECFs | | A, ✓ | | | | | |
| 47. Use of Government Revenues [†] | | | | | | | |

(See coding chart next page)

1993 House of Delegates – Actions on Resolutions

| Resolution # and Name | Referred to Council | Adopted | Rejected | Resolution # and Name | Referred to Council | Adopted | Rejected |
|--|---------------------|---------|----------|--|---------------------|---------|----------|
| Liability | | | | Reimbursement | | | |
| 72. Medical School..... Scholarship for Service in Underserved Areas | ✓ | | | 11. Medicare Reimburse- ment for Medications | | | ✓ |
| 73. Access to Health Care..... | ✓ | | | 12. Medicare Reimburse- ment for Medications | ✓ | | |
| 29. Tort Reform..... | ✓ | | | 13. Single Payment Level..... for Medicare | | CC | |
| 30. Limitation of Awards..... in Torts | | CC | | 14. Statewide Fee Sched- ule Implementation | | | ✓ |
| 31. Expert Witness..... Testimony | | A, ✓ | | 15. Request for Review by AMA CPT Editorial Panel | | A, ✓ | |
| 41. Malpractice and the..... Indigent Patient | | A, ✓ | | 16. CPT Code Modifier to..... Describe Physician Office Laboratory Procedures | | CC | |
| Public Health | | | | 17. CPT Global Surgery..... Definition | | CC | |
| E1. Nurse Practitioner..... Pilot Projects ¹ | | A, ✓ | | 18. Third-Party Payor in..... Office Evaluations | ✓ | | |
| E2. Opposition to Inde- pendent Prescribing by Physician Assistants ¹ | | A, ✓ | | 23. Opposition to RAP- DRG Proposal | | A, ✓ | |
| 27. Funding of Lead..... Screening | | A, ✓ | | 24. Commission on Office..... Laboratory Accredi- tation | | CC | |
| 28. Testing for Treatable..... Inborn Errors of Metabolism | | A, ✓ | | 68. Electronic Billing..... | | CC | |
| 59. Tanning Parlor Educa- tion and Regulation Initiative | | A, ✓ | | 69. Hospital Medical..... Records | | | CC |
| 60. Universal Access to..... Prenatal Care | | CC | | 70. Selection of Insurance..... Plans | | A, ✓ | |
| 61. Recycling of Lab Coats..... by Physicians and Medical Students | | A, ✓ | | Coding for Chart | | | |
| 62. Educating About the..... Hazards of Listening to Excess Decibels | | A, ✓ | | <div> <div> A, ✓ – Resolution amended, then adopted </div> <div> CC – Resolution placed on Consent Calendar, then either adopted or rejected </div> <div> † – Resolution withdrawn </div> <div> A complete list of the pro- ceedings will be available in July from the OSMA Department of Educational Services. </div> </div> <div> ¹ – Emergency Resolution ² – Substitute Resolution – Replaces Nos. 7, 8 ³ – Substitute Resolution – Replaces Nos. 34, 35, 39 ⁴ – Substitute Resolution – Replaces Nos. 36, 37, 38 ⁵ – Substitute Resolution – Replaces Nos. 49, 50 ⁶ – Substitute Resolution – Replaces Nos. 51, 52 </div> | | | |
| 63. Developing Smoke- Free Areas in Prisons and Jails | | A, ✓ | | | | | |
| 64. Educating About the..... Hazards of Smokeless Tobacco | | A, ✓ | | | | | |
| 65. Educational Programs..... for Women on the Effects of Smoking | | CC | | | | | |
| 66. Smoking in Teenage..... Females | | CC | | | | | |

Dr. Wolfe testifies on Workers' Comp bill

In Brief: OSMA's new president-elect testified before a House committee on drawbacks to current legislation that proposes a managed-care system for the Workers' Compensation program.

OSMA's new president elect, Claire Wolfe, MD, made it clear in testimony before a House committee in early May that the Bureau of Workers' Compensation erred in not consulting with the OSMA on its new, reduced fee schedule for physicians, and in not providing the association with information on its schedule until shortly before its implementation. (See related story on front page.)

Then, she went on to raise questions about House Bill 226, the bill sponsored by Rep. Ross Boggs (D-Andover) which, among other things, would turn the state's Workers' Comp system into a managed-care entity.

According to Dr. Wolfe, who chaired the OSMA's Workers' Compensation Task Force, there are significant problems inherent in establishing a managed-care sys-

tem for Workers' Comp. For example, if the system is set up as a PPO model, and a panel of Toledo orthopedic surgeons is put into place, would orthopedists in Allen County be denied the opportunity to care for Workers' Comp patients? And she pointed out that a gatekeeper concept is hardly appropriate for a system where patients don't seek preventive care but, instead, treatment for an injury, usually serious, that's already been sustained.

"Who is the gatekeeper in this situation?" Dr. Wolfe asked committee members. "Is it the patient's regular physician, or a physician selected by the bureau, or an employer?"

"The committee's reaction to Dr. Wolfe's testimony was that she made some very good points that need to be thought through," says Dan Leite, assistant director of OSMA's Legislation department. Legislation committee members also expressed surprise that the OSMA was not consulted by the bureau when it sought to restructure physician reimbursements.



Claire Wolfe, MD, OSMA president-elect, testifies before a House committee regarding legislation that would affect the Bureau of Workers' Compensation.

NEW BILLS INTRODUCED

While the House committee continues to hear testimony on HB 226, two legislators have recently introduced their own Workers' Comp bills.

House Bill 302, introduced by Rep. Bob Corbin (R-Dayton), creates within the bureau a fee-advisory committee to review and update reimbursement rates. The

committee would include physicians.

Meanwhile, Rep. Jack Cera (D-Bellaire) has introduced House Bill 308, which would give physicians the right to negotiate fees and other matters with Workers' Comp officials.

The OSMA is currently studying both new bills and will follow them closely. ■

Managed competition bill promises universal coverage

In Brief: The bill would divide the state into regions and would restrict the number of health-care plans offered.

A managed competition bill, modeled after the concept being considered by the Clinton health-care task force, has been introduced in the Ohio Legislature. Known as the Ohio Universal Health Security Act, House Bill 341 and Senate Bill 142 would provide health coverage to every Ohioan by taxing employers and employees and by controlling health-care costs.

The bill is sponsored by Rep. Robert Hagan (D-Youngstown), who formerly authored legislation to bring a Canadian-style single payor system to Ohio. In the Senate, the bill is sponsored by Sen. Judy Sheerer (D-Shaker Heights).

The bill would:

- Fund universal coverage by

imposing a payroll tax on all employers and tax employees' income.

- Create a 16-member board, including two physicians, that

The bill would fund universal coverage through new taxes.

would be given broad authority to administer the act, such as establishing a standard benefits package and premium rates for that package.

- Divide the state into three regions and require that no less than three or more than five health-care plans be offered to employers in each region. A

freedom-of-choice plan would have to be one of those offered.

- Businesses and individuals would be organized into government-sanctioned buying cooperatives.
- Health-care costs would be restrained through volume buying, competition among health plans, and by government-set global spending budgets.
- Medical liability would be reformed by mandating alternative dispute resolution.

The OSMA is now in the process of analyzing and preparing its policy position on these bills. *OHIO Medicine* will keep you posted on these bills and any future position the OSMA may take on this legislation. ■

New legislators to fill vacancies

Changes have been taking place at the Statehouse this spring – namely in the membership of the Ohio General Assembly:

- State Sen. Harry Meshel (D-Youngstown) was elected chair of the State Democratic Party. Former State Rep. Joe Vukovich (D-Poland) has been appointed to fill the unexpired term of State Sen. Meshel.
- Jay Kirk Schuring (R-Canton) has been appointed to take the 55th Ohio House of Representatives seat, vacated by State Rep. Dave Johnson. Rep. Johnson was appointed a commissioner of the Ohio Public Utilities Commission.
- State Rep. Francis Carr (D-Alliance) has died following an illness. A new member will be appointed to fill the vacancy. ■

Photo by Jack Kustron



Doctor-Patient Sex Bill Unnecessary

Victoria Ruff, MD, Columbus, testified recently on House Bill 102, the bill that prohibits doctor-patient sexual relations. Dr. Ruff, a member of the AMA Council on Judicial and Ethical Affairs, presented the OSMA's position that this bill is unnecessary since ethical guidelines already forbid this type of physician misconduct.

Bill would merge Ohio's Blues

In Brief: A new bill would merge Ohio's Blue Cross plans and require them to offer employees of small companies a basic health plan despite their present health conditions.

State Rep. Paul H. Jones (D-Ravenna) has introduced a bill that would force the merger of Ohio's three Blue Cross plans and require the new company to offer a basic health-care plan to those Ohio businesses that employ between two and 50 people. This coverage would be offered regardless of the employees' present health condition.

According to newspaper reports, the Blues have taken various positions on the legislation. The Cleveland-based Blue Cross and Blue Shield of Ohio opposes writing a no-questions-asked insurance policy but agrees that a merger makes sense. Cincinnati's Community Mutual is opposed to the idea, however, and Columbus Central Benefits believes it should not be included in such a merger.

Ohio is surrounded by states that have a single Blue Cross plan

(Michigan, Indiana, Kentucky and West Virginia), and across the nation at least 40 states have single plan Blue Cross-Blue Shields.

MERGER WOULD LOWER PREMIUMS

Rep. Jones has said his bill was drafted as the result of a letter sent by Ohio AFL-CIO President John Hodges to state leaders. Hodges said in his letter that a larger company would not only prove more cost-efficient (resulting in lower premiums), but could also compete more easily for any regional processing centers expected to emerge from a national health plan.

Initially, control of the new, merged Blue Cross-Blue Shield would be given to a board controlled by state appointees – a provision that is already drawing criticism from some legislators, who liken that kind of control to that maintained by the board at the Bureau of Workers' Compensation.

The OSMA is studying the proposal and has not yet taken a position on it. ■

Bill requires physicians to give mammography reports to patients

Physicians will be compelled to give patients who request it a written copy of their mammography report if House Bill 215 passes the Ohio Legislature. The bill, sponsored by Rep. Randy Weston (D-Marion), originally called for physicians to also provide a copy of the X-ray film to the patient as well, though that provision has since been removed at the OSMA's urging.

As with the doctor-patient sex bill, the OSMA has once again taken the tenuous public relations position of opposing this legislation, a stance also taken by the Ohio State Radiological Society, which has been working in tandem with the OSMA to defeat this bill.

"Again, we believe this bill is unnecessary," says John Van Doorn, director of OSMA's Department of Legislation. "Physicians' ethical guidelines say a copy or a summary of a report should be given to

patients at their request. Legislation mandating them to do so is unnecessary."

DOCTORS TESTIFY

Carol Solie, MD, a gynecologist with the Marion Breast Health Center in Marion, and Lucy Freedy, MD, a Columbus radiologist, have both testified in support of OSMA's position before the House Human Resources Committee, where the bill is being heard.

Still, the bill seems to have popular support, and that may persuade legislators to vote for it. At least, if the bill passes in its present form, physicians won't have to worry about providing patients with anything except a written report. The film and any copies of it will remain with the physician, hospital or testing facility. ■



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Allied practitioners could gain more power under HB 183

In Brief: Not only would this legislation increase the scope of practice for two groups of allied practitioners, but another provision would mandate doctors in Butler County to take their "fair share" of Medicaid patients.

House Bill 183, sponsored by Paul Jones (D-Ravenna) and just recently introduced at the Statehouse, may be one of the most onerous bills for physicians produced this year. The bill has three major provisions – two seek to expand the scope of practice for two groups of allied practitioners, and a third establishes a demonstration project in Butler County that would compel physicians there to take a "fair share" of Medicaid patients into their practices.

Here's a closer look at the provisions:

Physicians Assistants

- The bill would make physicians' assistants "institutionally employable," so that hospitals could hire them as well as physicians, and

would allow PAs to prescribe controlled substances, subject to a physician's review. In addition, the PAs' regulatory committee would practice independently of the State Medical Board in disciplinary matters, although the board would be called upon to adopt those recommendations made by the committee.

Nurses

- The sponsor is entertaining language that would allow nurses to practice independently and allow them to prescribe drugs in underserved areas. (See related story.)

Medicaid Project

- A provision by Rep. Michael A. Fox (R – Hamilton) would create a Medicaid demonstration project in Butler County, where a board would be created to do two things: set up a "fair share" program, compelling physicians to take their "fair share" of Medicaid patients in their practices, and also expand the nurses' scope

of practice in that area.

Stanley Ignatow, MD, president of the Butler County Medical Society, has met with Rep. Fox to express the society's opposition to

the provision, as well as to the entire bill itself.

"The bill is presently in the House Health Committee," says John Van Doorn, director of OSMA's Department of Legislation. "The OSMA is obviously opposed to this bill, and we will do what we can to defeat it." ■

Nurses may make legislative move

House Bill 478, the state's new health-reform law, is setting up two nurse pilot projects, one in Cleveland and one in Dayton, that will allow nurses to practice independently and to write certain prescriptions.

Now, it appears that one and possibly two more nurse pilot programs will be authorized in the budget bill. One project would be set up in Cincinnati, another probably in Columbus.

Recently, at the invitation of the Ohio Nurses Association, a number of OSMA members met with a group of ONA members to hear their proposal for independent practice in Ohio.

"We listened to what they had to say and we offered no reac-

tion," says Claire Wolfe, OSMA's president-elect. (In fact, at OSMA's recent Annual Meeting, the House of Delegates adopted a resolution that acknowledges the value of nurse practitioners, but opposes more pilot projects until the current programs are evaluated.)

The meeting may well turn out to be a forewarning of other legislation proposed by the nurses to set up independent practices around the state. Now that the physicians' assistants have made their proposal to the Legislature, the nurses, encouraged by what appears to be a sympathetic federal government, are likely to make their own legislative move soon.

House, Senate committee to consider budget bill

In Brief: A joint committee will work out House and Senate differences on such matters as physician license fee increases and increased Medicaid reimbursements.

By the time you read this, the state's budget bill will probably be enroute to a joint conference committee where House and Senate differences will be worked out prior to the bill's appearance on the desk of Gov. George V. Voinovich for his signature.

As *OHIO Medicine* reported last month, there are several provisions in the budget bill that are of interest to physicians. Here is an update, as of press time, on these provisions:

License fee increase...The Senate is likely to increase the medical board's proposed fees for physi-

cians to \$200 or more before it goes to the joint committee. The board had originally requested the physician fees be raised to \$300, but, through OSMA efforts, that figure was lowered in the House to \$200. The OSMA has taken the position that fees should not be raised to more than \$200, and it will continue to work with the joint committee to try to keep physician license fees within that range.

Medicaid reimbursements...The proposed \$39.9 million increase in Medicaid reimbursements to physicians is likely to survive the Senate, but there is a virtual certainty that this increase will be targeted to primary care services and not to specialties. The House added an amendment that places Medicaid patients under a primary care case-management system, and that amendment will probably

survive, along with the proposed increase.

Women's Health Initiative...

New to the budget bill, thanks to Sen. Karen L. Gillmor (R-Old Fort), is a provision that creates an Office of Women's Health Initiatives, housed within the Department of Health, at a cost of about \$100,000 a year. The office would identify and help find resources for health issues that affect women, such as increasing the rate of regular mammography screening and prenatal care. Although the ODH currently has a coordinator for women's health issues, this new provision calls for the hiring of a director and a third staff member for the office. The OSMA supports this effort. ■

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HealthCare REFORM



A Round-Up of National Proposals

With Hillary Clinton's Health-Care Task Force report still months away, some state governments aren't willing to take the same wait-and-see attitude that Ohio has. A variety of health reform proposals are being studied by a number of state legislators. Here is a brief round-up of what's out there so far:

- **California** – Three million indigent Californians would be provided basic medical services in free countywide health plans, under a proposal by Gov. Pete Williams.
- **Connecticut** – Insurers would be barred from settling small business rates according to the claims they've filed, and would be forced to open preferred-provider networks to any qualified doctors. A 6% sales tax on hospital services would be added to the state's 1994 budget to provide coverage for the uninsured.
- **Kentucky** – May require employers to insure their workers or pay a payroll tax to cover the uninsured.
- **Louisiana** – Considering creating managed health-care organizations to contract with doctors and hospitals.
- **Massachusetts** – Would put Medicaid recipients into managed care organizations and cut some benefits.
- **Maryland** – A proposal would prohibit insurers from denying coverage to those with pre-existing conditions and limit doctors' fees.
- **Michigan** – About 800,000 children, whose parents earn too much to qualify for Medicaid, would be provided state-paid health coverage at a cost of approximately \$51 billion.
- **Missouri** – One proposal would fund a comprehensive single-payor plan by employer payroll tax and a graduated income tax surcharge. Another bill would increase tobacco tax to expand coverage to children and pregnant women.
- **New York** – Regional health networks have been proposed, as well as a cap on doctors' fees.
- **Oregon** – Has begun to "ration" care by extending government-funded health care to more poor and disabled by eliminating payment for some services.
- **Tennessee** – Wants to restructure the Medicaid program.
- **Texas** – One bill offers small businesses three health insurance packages: bare bones, in-hospital and comprehensive.
- **Washington** – Has a plan to provide subsidized health coverage for 450,000 uninsured by 1997.
- **West Virginia** – The Medicaid plan would impose a \$95 million new tax on health-care providers. Also under study: minimum health benefits package, uniform billing system, insurance reform, including community rating.
- **Wisconsin** – Local purchasing pools may be created to test a new system of controlling services and costs.

Ohio Health-Care Reform Board traveling around state

The new Ohio Health-Care Board, established last year by Ohio's health-care reform legislation, House Bill 478, has been meeting monthly since April, traveling around the state as it tackles major health-reform issues.

So far, the meetings have been primarily organizational, reports Herb Gillen, OSMA's senior director who has attended several of the meetings. "They're discussing by-laws, developing their mission statement, working on objectives and setting priorities," he says.

SUBCOMMITTEE APPOINTMENTS

Subcommittees, dealing with cost, access and quality issues, are also beginning to form, and the board's two physician members

have already been appointed to a few of these. William Porterfield, MD, Columbus, representing HMOs, will chair the subcommittee studying the basic level of

The board is expected to offer health-care reform recommendations by January 1.

health benefits, and will serve on the subcommittee to create a standard claim form. Claire Wolfe, MD, OSMA's president-elect, who is representing physicians on the

board, will serve on the subcommittee for malpractice reform.

The board will open its meetings to public testimony as it makes its tour around Ohio, and Gillen says physicians may come to future meeting sites to testify on the profession's concerns.

REPORT DUE JANUARY 1

Ultimately, the Ohio Health-Care Board is expected to offer recommendations on health-care reform to Gov. George V. Voinovich by January 1, then continue to serve the state in an advisory role on health-care issues. Included on the board are representatives of businesses, insurance, consumers and government.

In an initial meeting of the board,



Gov. Voinovich told the group that their job is to develop reform recommendations that can fit the framework of a national health plan, and develop ways to bring down health-care costs.

"I am concerned about access, but our number one priority is to... control costs so people who have insurance can keep it," says Gov. Voinovich, in an article in the *Columbus Dispatch*. "I want Ohio to lead the way in bringing down costs." ■

Wisconsin plan studied by OSMA health reform task force

In Brief: A representative of the State Medical Society of Wisconsin recently told the OSMA how his group developed a health-care reform proposal on behalf of Wisconsin physicians.

In April, the State Medical Society of Wisconsin House of Delegates approved a controversial yet credible health-care reform plan that had been hammered into shape by a special physician task force.

Wisconsin's task force is similar to the one formed in March by then-OSMA President Stanley J. Lucas with the goal of creating a health-care reform plan for Ohio's physicians.

Hoping to gain from the Wisconsin experience, the OSMA task force invited Kenneth M. Viste, Jr., MD, chair of the Wisconsin committee, to review, step by step, the process his group used to arrive at their reform proposal.

"Of course, what works in one state may not work in another," Dr. Viste warned the OSMA task force when he met with them in late April.

Still, the Wisconsin plan seems to be a valid model for the OSMA. It is already being viewed by legislators in that state as a serious proposal, and Dr. Viste indicated that "Wisconsin Care," as the plan

has been titled, is likely to be introduced in its entirety.

Yet "Wisconsin Care" did not develop easily. At times, discussions became difficult, as a wide mix of physicians from different specialties and geographic areas argued through parochial interests. The Wisconsin group studied state level activities, key national proposals and plans from other medical organizations before arriving at their final proposal. In February, seven months after the project's initiation, the task force finally submitted its proposal to the association's board.

The Wisconsin plan has gains as well as sacrifices, says Dr. Viste.

"The ultimate goal was to ensure access to quality care services for all residents while controlling costs," he says. To accomplish this,

Wisconsin's goal was to ensure access to quality care for all residents while controlling costs.

the Wisconsin task force believed everyone – employers, insurers, physicians and patients – had to assume responsibility and make sacrifices.

Key features of the Wisconsin plan include:

- A guaranteed standard benefit package for all Wisconsin residents.
- A "play or pay" plan that would force all employers to provide coverage for workers or pay a tax into a general health-care pool.
- A state health-care subsidy for those with incomes less than 200% of the poverty level.
- A state health-care commission to develop the standard benefit



Wisconsin medical society representative Kenneth M. Viste, MD, left and OSMA President Walter A. Reiling, Jr., MD, listen during a recent OSMA health reform task force meeting.

plan, certify insurers who offer the plan and oversee the plan selection by those not covered through employment. The health-care commission would

value scale, with physicians setting their own conversion factors to ensure uniform payment. This new system of payment is designed to increase support for primary care. Wisconsin physicians supported the new payment changes because the result enhances primary care and preventive care services, particularly in the rural areas. Physicians were willing to give up balance billing as part of the bargain.

Physicians are also being encouraged to form and participate in integrated health plans, similar to today's managed care models.

These could take the form of managed care with capitated fees.



also formulate and implement practice parameters in partnership with physicians.

INSURERS

In addition, the Wisconsin plan includes some health insurance reform. According to the proposal, insurers would bid to have their health plans certified by the state, and would have to meet new insurance standards such as accepting all applicants, eliminating denials due to pre-existing conditions, pricing premiums on community rates and renewing all policies.

PHYSICIANS

Wisconsin physicians would be paid based on a statewide relative

HOSPITALS

Hospitals would be paid under a new payment system based on DRGs. Hospitals are also encouraged to become involved in integrated health plans.

While there was broad consensus among Wisconsin physicians about the overall goals of the health-care reform proposal, there was considerable disagreement over the details, says Dr. Viste. Still, an agreement was eventually reached, and the plan is likely to be introduced at the Wisconsin Legislature in its entirety.

The OSMA task force hopes to arrive at a similar consensus on a reform proposal by the end of the year. ■



Task force member J. Robert Navarre, MD, listens during a recent meeting.

PRESIDENT'S PERSPECTIVES

Assuming the mantle

In preparation for my upcoming year as your OSMA president, a certain amount of advanced planning was required; schedules had to be arranged, committees appointed, meetings with the

I never dreamed that someday I would be afforded the privilege of serving as your OSMA president.

association's staff attended, provisions made for practice coverage, etc.

For me, it was also a time of personal reflection, a time to establish goals and a time to examine and evaluate my philosophical approach to this important office. How did I wish to be perceived,

and more importantly, from what perspective should I base my judgments and decisions? Was there a basic philosophy I should adopt to guide my actions?

I reviewed my background relationship with the OSMA. In 1978, as a then-young general surgeon from Dayton, I was elected an alternate delegate to the OSMA. At that time, I never dreamed that someday I would be afforded the privilege of serving as your OSMA president. Neither could I have predicted I would assume that office at a time so critical to our profession. Back then, my medical priorities were quite clear. First came my patients and my practice, and, secondly, my interest in organized medicine and my involvement in a new medical school, Wright State School of Medicine.

Reflecting further, I was somewhat surprised to realize my priorities remain the same today – they are totally unchanged from 1978! My first priority remains my



Photo by Diana McNees

Walter A. Reiling, Jr., MD, is installed as OSMA president.

patients and my practice. I suspect that will not change during my term of office.

Reading this may cause some to raise an eyebrow. What about your duties and responsibilities to this organization, you may ask.

I can assure you I will devote much energy and time to our organization, but as I travel this

state, as I meet legislators and government officials, as I testify on your behalf, and as I make the many necessary important judgments, I believe this organization will be best served if I look upon myself and others look upon me as first, a practicing physician who secondarily happens to represent the physicians of Ohio. ■

OHIO Medicine

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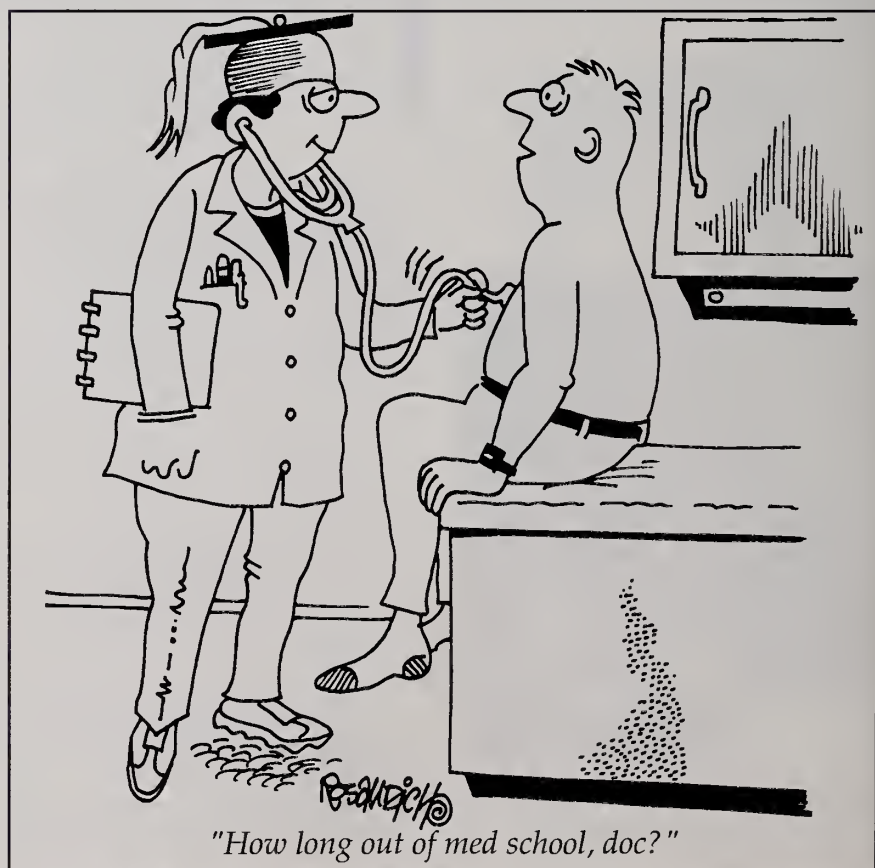
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OSMA welcomes
letters to the editor:

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LETTERS TO THE EDITOR

OHIO Medicine topics draw comments

To the Editor:

Re. Senate Bill 29, corporal punishment – The more I thought of it, the funnier it became. The point that is so amusing is, are we supporting or initiating legislation that will protect the students or teachers? We are worried about the teacher smacking a student who is disruptive in class, but not the student who brings a semi-automatic gun, knife, other weapons, even drugs to class. Where are your priorities? I hope Dr. Reiner remembers that the threat of the ruler across the hand or buttocks made better students of those that were there to learn, in days past, but who may have had a moment of indiscretion. Now, 40%-50% of students can't pass a ninth-grade proficiency test, and must be given nine chances to pass. What a waste of legislative time when there are so many more important matters that need to be addressed.

Re. House Bill 18, Senate Bills 7 and 9, assisted suicide – Many European countries have legalized euthanasia as patient-directed care of themselves. Why are we so narrow-minded?

Re. House Bill 183, mandating physicians to treat Medicaid patients – In the footsteps of HB 478, the last carrot used was determining income levels or be fined by Medicare if you didn't participate. So, 84.7% now do. An increase of 21.3%. Now, with Medicaid, there is no income level to inquire about, so just take care of your fair share. The right of free choice is going out the window in this free country. Whatever happened to Darwin's idea of survival of the fittest when it comes to welfare? Please make sure that department stores take their fair share of welfare recipients' purchases without money.

Re. Dr. Nigro's editorial – Since Dr. Nigro thinks physicians should not be business people, and only in the profession for the good of mankind, with fee caps, why should the CEO of IBM, Chrysler, etc. make millions in annual compensation? Why should the golfer make \$450,000 over a week-end playing golf? I am sick and tired of others, including Dr. Nigro, who think physicians make too much money because they work 12- to 16-hour days. The incentive to work in this country is almost gone. That is why we have such problems with Workers' Comp, welfare and other entitlements.

Re. Medical board fee increase – They have no control of the funds, so why another increase?

BERNHARD BERGER, MD
Canton

Retirees speak out on license fee increase

To the Editor:

I would like to comment on the proposed license fee increase. I retired prematurely in 1984 because of open-heart surgery and am on a fixed income. Such an increase would present an economic financial hardship.

Provisions or exceptions should be made for retired physicians, not in active medical practice but desiring to maintain a valid medical license.

S. VECHEY, MD
Fort Lauderdale, Florida

To the Editor:

Concerning the medical board's proposal to raise license fees. I wish to inform you that, as a fully retired physician, I consider any raise of my license fees to be unfair, not only to me but to all retired Ohio physicians.

The only reason I keep my license is a matter of pride, and the need to continue to be part of the medical profession.

Fully retired physicians should not be asked to pay any increase and shouldn't be required to pay any fees, considering that we have paid fees and membership dues for many years.

ANTOINE M. HAROUNY, MD
Hudson

License fee could reach \$600 per year

To the Editor:

I am writing to strongly object to any increase in my licensure fees.

I am a physician in practice, and within the last two years, licensure fees have been raised twice. At the rate of proposed increases, by 1996, we'll be paying \$600 a year for licensure fees, and for questionable services to benefit from that money spent.

If the money was earmarked for specific needs of the health-care professions, then perhaps, but I am highly wary of having funds that will be accessible to the Legislature for other uses, and I don't believe in giving more money to politicians. They always have ways to spend it.

ALBERT H. BELFIE, DO
Springfield

SECOND OPINION

OSHA shouldn't practice medicine

By Albert J. Camma, MD

The meddlesome Washington bureaucracy has struck again! The OSHA regulations for blood-borne pathogens adds another layer of absurdity and interference between patients and physicians. Under threat of Gestapo-like surveillance by spies masquerading as patients and health-care providers, OSHA intends to ensnare physicians and hospitals and charge them exorbi-

tant fines for not wearing gloves, goggles, masks, etc. Considering that the proper handling of potentially infectious material in patients is an integral part of the medical training of all physicians and health-care personnel, we hardly need a set of regulations from OSHA to tell us how to do it. Furthermore, we do not need another expensive bureaucracy to stand guard over us. Finally, has anybody told OSHA what the costs of

all of the gloves, splash protectors, eye shields, etc. will be? Is OSHA aware of the problem of escalating health-care costs?

The purpose of all of this costly maneuvering is to decrease exposure to pathogens and yet OSHA has within its power to do this easily and effectively. Every patient admitted to a hospital should have an automatic test for HIV and hepatitis! Unfortunately, instead of having the intestinal fortitude to

grab the bull by the horns and challenge a very vocal minority of people, OSHA has chosen this very expensive means to circumvent the issue. I find it very difficult to have any respect for this Washington bureaucracy! ■

Albert J. Camma, MD is a neurosurgeon practicing in Zanesville.

ALLIANCE REPORT

Change is growth, not uncertainty

I accept with pride the role of leadership for the Ohio State Medical Association Alliance. I thank all of our members for the opportunity to serve. I begin my year with the motto of "Communicating the Challenges and Changes Facing Medicine." I challenge all of our members and Ohio physicians to combine their energy and ideas to meet the changes that are facing medicine as we approach the 21st century.

As partners in medicine with our spouses, we must work together and share our concerns, especially at the county level. We are on the front lines and must show that physicians and their families care about a quality health-care system. We provide countless volunteer hours. It is up to us to help communicate the sacrifices and the

hassles that physicians and their families endure to give the best health care possible for all their patients. I have seen, firsthand, the misconceptions, honest ignorance and lack of information that people perpetuate about physicians. As allies of medicine, we must become aggressive in marketing our health programs, our spouses' perspectives on health care and the needed changes.

We must actively seek out the leadership in our communities and network with the various community organizations in our hometowns to deliver medicine's point of view and the alliance's many projects. We must be aggressive in getting our message out. Our visi-

Valerie Vollmer,
President



bility is vitally important.

Change is growth and progression, not uncertainty. Now more than ever we must move ahead with some changes and meet new challenges that will determine the status of the profession of medicine. If we do not meet the new challenges and take part in the many new changes, someone else will certainly take it on for us. ■

News & Views

Scare of the month

What is the national scare we are to be assailed with this month? Are you as tired as I am of "new" discoveries every month about the health hazards supposedly found in our air, water, food and environment? I'm sick of hearing about alar in apples, benzene in Perrier water, mercury in our dental fillings, asbestos in buildings, lead solder in copper pipes, radon in homes, etc., ad nauseum. Has the time come when your government should no longer permit these scares to be publicized until controlled studies show a possible hazard is truly a hazard?

W.B. Rogers, MD
Cuyahoga Falls

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SRF notices have been mailed

If you are eligible for a refund from the remaining money in the Stabilization Reserve Fund, you should have already received your notification letter and claim form from the SRF.

Its certified mailing to all known eligible recipients was completed by the end of April. Letters have

been sent to original contributors, based on SRF records, at the most current address available. The OSMA, in addition to other professional associations, assisted the SRF with updating its mailing list. Newspaper notices about the SRF refund process are being placed in local newspapers, as mandated by

legislation.

Physicians eligible for refunds now have 180 days – until November 12 – to mail in their claim forms for their refund. Only one claim form should be presented for each SRF contributor. If you have not yet received a proof-of-claim form, you should request one by writing the SRF at P.O. Box 267112, Columbus, OH 43226. Any claim received by the SRF after the November 12

deadline will not be paid.

The SRF expects to begin mailing refund checks by mid-November.

Anyone who would like more information about the SRF refund process should call the SRF at (614) 888-8901 or Herb Gillen, OSMA's senior director, at 1-(800) 766-OSMA or (614) 486-2401. (See the related story below.) ■

Answers to Questions About the SRF Refund

Both the OSMA and the Stabilization Reserve Fund are still receiving numerous questions about the SRF refund process and the refund itself. The March issue of *OHIO Medicine* answered some of the most commonly asked questions in its "Association News" section. Now that the SRF notification letters have been sent, however, we believe the answers to some of those questions bear repeating. We've also added some new questions and answered those as well.

Q. Who is eligible for a refund?

A. You are eligible for an SRF refund only if you practiced in Ohio and carried medical liability insurance coverage during the years 1976-1979. These physicians were required to contribute to the Stabilization Reserve Fund.

Q. Will I be notified if I'm eligible for a refund?

A. You should be. The SRF, with the assistance of the OSMA and other professional groups, has made every effort to notify eligible physicians by mail. In addition, to catch the attention of those it might have missed, the SRF has placed notices in local papers and publications like *OHIO Medicine*. However, it is always possible that you may be eligible for a refund and still not have received a notice. If that is the case, please write the SRF board for an application form.

Q. How much money will be returned to me?

A. Specific figures are difficult to arrive at. However, you will receive a minimum of \$500 (see question below) plus the amount of interest that money has earned since 1976. If you secured your insurance through the Joint Underwriting Authority at that time, you had to pay an additional surcharge, so an additional amount of money will be returned to you, also with interest.

Q. I remember that some SRF money was returned to me in 1981. Will that affect the amount of this current refund?

A. Again through the efforts of the OSMA, half of the SRF funds were returned to policyholders in 1981, and, yes, that will affect the amount you receive. Physicians paid \$250 over four years (\$1,000) into the fund. Half of that amount (\$500) was returned in 1981. That's why the new minimum refund is \$500. It's half the sum of your original contribution.

Q. How do I claim my refund?

A. You must complete a proof-of-claim form that is being distributed by the SRF and return the form to the SRF by no later than November 12, 1993. You will not receive a refund unless you submit a claim. Claim forms

may be obtained from: The Stabilization Reserve Fund, P.O. Box 267112, Columbus, OH 43226-7112, (614) 888-8901.

Q. What happens to the refund if the physician eligible to receive the money is deceased?

A. The SRF will release the refund to the widow(er)s and estates of deceased physicians if a proof-of-claim form is completed and returned before the November 12 deadline. Any OSMA member who may know of a widow(er) entitled to a refund should let the SRF know at once so the agency can check the name against its records.

Q. What happens if a corporation (for example, a hospital or group practice) paid the premiums for one or more physicians? Will the corporation receive an SRF notification letter?

A. No. The notification letter was sent to those parties named as policyholders, not to those who paid the bills. Likewise, refunds will be mailed to policyholders, not the entity that paid the bill. If the corporation believes it should receive the refund, it will have to collect it from the policyholders.

Q. I purchased my insurance at that time, as mandated, through the Physicians

Insurance Company of Ohio, and I also was required to purchase PICO stock. What relationship does this refund have to my current PICO stock? Will I lose shares as a result of the refund?

A. No, the return of the Stabilization Reserve Fund monies and PICO stock is totally unrelated.

Q. When will I receive the refund?

A. At this time, the JUA hopes to have the SRF checks in the mail by mid-November.

Q. Do I have to declare my refund on my 1993 tax return?

A. The best advice here is ask your tax consultant. A 1099 form will be sent along with each refund check, and your interest will be noted separately from the amount of money that you have contributed to the fund. Whether or not you must pay taxes may depend on whether or not you claimed a deduction on the payment – but check with your accountant.

Q. Where may I get further information or ask additional questions?

A. Two sources. Call the SRF at (614) 888-8901 or call Herb Gillen at the OSMA at 1-(800) 766-OSMA. ■

County Notes

■ Lorain County

Former U.S. Surgeon General Antonia Novello, MD, at right, visited Lorain County this past spring to make a presentation to area health-care professionals. With her, from left, are: Daniel Zaworski, MD, president of the Lorain County Medical Society; Joseph Novello, MD, Dr. Novello's husband; and John W. Thomas, MD, OSMA Eleventh District Councilor.



■ Franklin County

Any indigent or uninsured individuals needing primary medical care can visit the Physicians Free Clinic located on the near-west side of Columbus. The Academy of Medicine of Columbus and Franklin County developed and sponsors the free clinic every Monday evening from 6:30 to 8:30 p.m. Each week one family practitioner or an internist and a pediatrician is joined by two subspecialists. All of the physicians volunteer their services. Other specialists will work on a referral basis.

Also, physicians of Franklin County presented the Academy of Medicine of Columbus and

County Foundation with a gift of \$22 million. The foundation will use the money for health-related activities in central Ohio. The donation came from the sale of Physicians Health Plan.

■ Hamilton County

The Academy of Medicine of Cincinnati's Legislative Committee is reactivating its Key Contact Program and is asking members to volunteer. Physician volunteers are asked to acquaint themselves with a local legislator and keep him/her informed on medically related legislative issues. If a bill is scheduled for a vote at the state or national level, for example, OSMA

will call on these key physicians to contact their legislator and let him/her know how the bill's passage or defeat would affect the practice of medicine.

■ Summit County

A pilot project offering prepaid legal services for members and their employees is being tested in Summit County. A pilot group of 100 enrollees will receive services from the law firm of Roderick, Myers and Linton for the nominal fee of \$5 per beneficiary per month. Some of the services provided include: wills, health-care power of attorney, a living will, a survivorship deed for a residence, and up

to four telephone or office consultations per year on any legal matter. The plan will not go into effect until the Medical Services Bureau, Inc., collects premiums from at least 100 beneficiaries for a six-month period.

■ Trumbull County

Live snakes were on the agenda at the Trumbull County Medical Society meeting recently. The special program, Snakes Alive, was designed to educate physicians about snake identification and the proper treatment for snake bites.

The 40+ physicians in attendance received 2 hours CME Category I credit. Participants spent the evening identifying the various reptiles. Robert Brodell, MD, Trumbull County Medical Society president, pointed out that physicians aren't taught much on identifying snakes or bites. And although treating snakes bites may not be a common office procedure, physicians should be aware that two poisonous snakes are found in Ohio.

Fractured Phrases

Editor's Note: More from OSMA Senior Director Herb Gillen's collection of homespun homilies, gathered at the meetings he attends.

FAMILIAR PHRASES – WITH A TWIST

You could put your head to their ear and hear the ocean.

No good deed shall go unpublished.

I've never been able to talk until I had something to say.

If the shoe's tight, it will holler.

Apples never fall far from the tree.

We have to go out on a limb sometime – that's where the fruit is.

Every dog is entitled to one free bite.

The chickens are coming home to roost.

There is nothing new, everything is stolen from a thief.

They've painted the same horse a different color.

If you burn your candle at both ends, may you have an extra wick in your pocket!

The older I get, the better I was.

It's only at the tree loaded with fruit that people throw stones.

The turtle only makes progress when he sticks his neck out.

A rising tide lifts all boats.



Flight Bag.

In the Air National Guard flight surgeons operate somewhere their beepers can't, 28,000 feet straight up. So if you're tired of your everyday routine spend a weekend a month and two weeks a year with the Air Guard. The work is important and rewarding. You'll enter as an officer and then the sky's the... you know. Call 1-800-548-5541 today and find out more.



Americans at their best.

Colleagues

JAMES J. AUGUSTINE, MD, Dayton, was elected chair of the State Board of Emergency Medical Services for the Division of Emergency Medical Services, Department of Public Safety. Dr. Augustine, chief executive officer of Premier Health Care Services, is chair of the Department of Emergency Medicine, associate director of Emergency & Trauma Center and medical director for emergency medical services at Miami Valley Hospital.

ANTOINETTE EATON, MD, Columbus, was appointed to the Advisory Committee on Infant Mortality of the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Dr. Eaton is director of governmental affairs at Children's Hospital.

GERALD R. EHRSAM, MD, Newark, was elected "Physician of the Year" at Licking Memorial Hospital. Dr. Ehram, who has a practice in internal medicine, has been on staff at Licking Memorial since 1976.

RONALD M. FERGUSON, MD, Columbus, was named chair of the Department of Surgery at The Ohio State University College of Medicine.



Ferguson

Dr. Ferguson is a professor of surgery and director of the division of transplant surgery at Ohio State, and is medical director of University Hospital's tissue typing laboratory.

GRACE HOFSTETER, MD, Canton, was elected secretary-treasurer of the Ohio Medical Directors Association.

ALAN MESHEKOW, DO, Canton, was elected to the board of governors of the American College of Osteopathic Surgeons. Dr. Meshekow is chief of staff at Doctor's Hospital.

ALEXANDER P. ORMOND, JR., MD, Akron, was elected president of the Ohio Affiliate of the American Heart Association, 1992-1994.

Dr. Ormond is on staff in the cardiology department at Children's Hospital Medical Center of Akron.

JERRY K. SHELL, MD, Springfield, was named president of the medical staff of Mercy Medical Center. Dr. Shell has served as

director of Mercy Medical's Ophthalmology Department since 1986.

YONG D. SONG, MD, Portsmouth, was elected president-elect, and **NORMAN JACOBS, MD**, was elected secretary-treasurer of the Scioto County Medical Society.

ERIC SVENSON, MD, Boardman, was installed as president of the Mahoning County Medical Society. **CHESTER A. AMEDIA, MD**, was elected president-elect; **DOUGLAS M. GOLDSMITH, MD**, secretary; and **NORTON I. GERMAN, MD**, treasurer. ■

A special invitation to medical practice executives from the IBM Medical Management Team.

The IBM Medical Management Team invites you to participate in the Medical Practice Executive Forum. At this special event, you will get an inside view of healthcare reform, examine changing technology needs and discuss critical issues that face medical practices in the '90s.

This important seminar will show you how to process billings and payments more quickly, improve collections and streamline operations. IBM and IBM Business Partners, who understand your business needs, will be there to demonstrate their medical management application solutions for you. And you'll also have a chance to share valuable insights with colleagues.

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Domestic violence campaign lauded

The OSMA's domestic violence program received high marks in a recent survey of Ohio primary care physicians.

The program, the Ohio Physicians' Domestic Violence Prevention Project, was launched in October 1992 after a survey the OSMA conducted earlier in the year indicated that Ohio physicians had a low awareness level of all forms of family violence, including domestic violence.

In the follow-up survey, physicians who received the OSMA's domestic violence educational materials rated the program highly. Of those who had used the materials, 95% said the materials were either very useful or somewhat useful. Respondents also showed that they are gaining confidence in approaching patients about the issue of domestic violence, with 85% of those responding indicating that they feel very comfortable or somewhat comfortable discussing the issue with patients. During the initial survey conducted a year ago,

only 76% of respondents said they felt very or somewhat comfortable.

However, increasing the recognition and treatment of domestic violence victims may take longer to accomplish. The percentage of

physicians who said they recognize and treat domestic violence victims did not change noticeably since the initial survey last year. At the time of this year's survey, the domestic violence materials had been available for only six months, and some physicians indicated that they had not yet had time to study them and

put the guidelines fully into use.

The OSMA Department of Communications has remaining copies of physician handbooks on domestic violence and on child abuse. To receive a free copy, call 1-(800) 766-OSMA. A third handbook on elder abuse will be distributed in September. ■

Campaign wins national award

The OSMA's domestic violence campaign, the Ohio Physicians' Domestic Violence Prevention Project, won a Gold Quill Award from the International Association of Business Communicators.

The domestic violence project received an award of merit in the category of external programs and campaigns. Judges felt that the strongest element of the project was the focused approach of the campaign and the effective use of the survey results.

The Gold Quill Awards program honors top work in the field and recognizes outstanding solutions to communication and other management problems.

Connie Roth Lechleitner, associate director of the Department of Communications, will accept the award at IABC's international conference in Chicago June 16.

THE JAMES... THE NEXT GENERATION OF HOPE

AT THE JAMES, IT'S A FINE LINE BETWEEN RESEARCH AND TREATMENT.

The Arthur G. James Cancer Hospital and Research Institute, a leading center for oncology research, diagnosis and treatment, opened its doors in 1990. Since 1977, the cancer program at Ohio State University has been committed to finding ways of eliminating cancer through the collaborative efforts of research and treatment of a nationally designated Comprehensive Cancer Center. The well-integrated relationship between many disciplines has created an approach that dramatically reduces the lag time between laboratory breakthroughs and practical application.

At present, experts at The James are investigating and administering visionary cancer therapies such as intraoperative radiation therapy (IORT), brachytherapy, taxol, 13-cis retinoic acid and numerous other therapies on patients from over 23 states and 2 foreign countries.

INTRAOPERATIVE RADIATION THERAPY

IORT, performed during surgery, utilizes targeted radiation to reduce or eliminate



tumors without penetrating overlying tissue or damaging noncancerous cells surrounding the tumor. At The James, IORT is administered in a specialized operating suite equipped with a linear accelerator capable of emitting six million to 18 million electron volts. During treatment, a circular cone is positioned on the tumor and laser beams are used to align the accelerator before the prescribed high dose of radiation is applied. A minimum of 70 patients annually will be treated in the IORT suite.

BRACHYTHERAPY

Brachytherapy, or radiation implantation, destroys cancer cells by delivering radiation directly to a tumor. Radiation oncologists place radioactive material inside or in close proximity to the tumor so that a very high dose of radiation can be delivered to the tumor with little of the radiation going to the healthy tissues around the tumor. Because healthy tissue remains undamaged, side effects are usually minimal.

The James, one of the leading pro-

ponents of brachytherapy, actively applies several forms of brachytherapy for various cancers and is one of the few centers to implant young children.

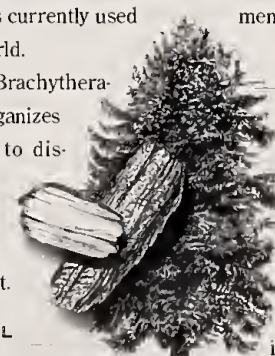
Early methods of brachytherapy often required surgery and lengthy hospitalization and exposed patients' families and nursing staff to radiation. Researchers at The James are spearheading efforts on several fronts to overcome these problems. High dose rate brachytherapy allows the treatments to be given in a few minutes on an outpatient basis while totally eliminating radiation exposure to the medical staff. Fluoroscopy and ultrasound can be used to guide the needles into tumors without requiring surgery to expose the tumor. The researchers at The James have combined the advantages of IORT and brachytherapy to deliver intraoperative high dose rate remote brachytherapy to tumors normally inaccessible to either IORT or brachytherapy.

Radioimmunoguided brachytherapy utilizes a hand held instrument that can detect the radioactive material remaining in small tumors yet not visible to the surgeon. A critical innovation in cancer



treatment, the instrument was developed at OSU and is currently used throughout the world.

The Section of Brachytherapy at The James organizes annual symposia to disseminate the latest information on this emerging oncology treatment.



TAXOL

The James has now treated patients from eleven states with taxol under a special National Cancer Institute Compassionate Use Program for patients with advanced ovarian cancer. In all, more than 54 patients have been treated at The James, the site of Ohio's only NCI-designated Comprehensive Cancer Center. This experimental treatment uses the scarce anti-cancer drug taxol, currently derived from the bark of the Pacific Yew tree. The taxol program at The James is designed only for women who have previously failed other treatment regimens and who have progressive disease. Other protocols using taxol in first line treatment are also available.

The Comprehensive Cancer Center is currently one of three centers in the United States using taxol in the treatment of breast cancer, and one of only

two centers using taxol in the treatment of head and neck cancer.

BORON NEUTRON CAPTURE THERAPY

Boron neutron capture therapy, which might offer significant promise for treating brain tumors, was first proposed by Dr. William Sweet in the 1950's.

Following the administration of delivery agents containing boron-10, the tumor is



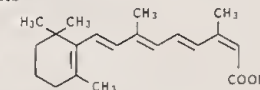
then irradiated with neutrons, resulting in a nuclear fission reaction yielding high energy radiation (alpha particles in Lithium-7 nuclei). A team of researchers at the Comprehensive Cancer Center is attempting to develop different boron delivery systems that will deliver amounts of boron to the tumor large enough to be effective. Researchers are also working in other aspects of BNCT, including the development of models to test therapeutic efficacy, alternative neutron sources and clinical treatment planning.

13-CIS RETINOIC ACID

A seven-year study of 13-cis retinoic acid currently is under way

to test the effectiveness of prolonged low-dose 13-cis

retinoic acid in reducing the risk of second primary tumors in patients who have had head and



neck cancer which has been controlled by surgery and/or radiotherapy. In addition, researchers are evaluating the kind and number of toxicities of low-dose 13-cis retinoic acid administered daily for three years.

PROGRESS AND POSSIBILITIES

Every day, tremendous strides are being made on many cancer fronts. Yet, it's a long way until total eradication of this ancient malady is achieved. However, the symbiotic relationship between research and treatment at The Arthur G. James Cancer Hospital and Research Institute forms a powerful wedge that is continually forcing the door open a little wider in the search for a cure.



THE ARTHUR G. JAMES CANCER HOSPITAL AND RESEARCH INSTITUTE

© 1993

CALENDAR

The OSMA, in association with Conomikes and Associates, Inc., has planned the following practice management workshops for 1993.

Medical Office Management Institute (MOMI)

These workshops have been designed for medical office managers, supervisors and key employees. Some offices have used these workshops to upgrade the skills of established personnel as well as for indoctrination of new employees. The following five-day workshops can be taken in any combination:

- effective personnel management techniques;
- improving your managerial effectiveness;
- patient flow management;
- financial management;
- improving your third-party reimbursement and coding.

June 28-July 2, Cleveland Stouffer Tower City Plaza, Cleveland

August 2-6, Cincinnati Kings Island Inn, Kings Island, Ohio

How To Run a More Profitable Practice

This one-day workshop is designed to show you the steps to a smarter, leaner and more profitable practice.

Sept. 28 - Marriott Airport, Cleveland

Sept. 29 - Concourse Hotel, Columbus

Sept. 30 - Marriott, Cincinnati

Can your patient's driving ability become your liability?

A patient you treat for epilepsy casually mentions to you that she's on her way to renew her driver's license. Do you say anything to the patient? Do you report her con-

dition to the Bureau of Motor Vehicles (BMV)? What about the patient, an admitted alcoholic, who regularly drives himself to his appoint-

ments? Or the patient you treat for violent moodswings or severe depression? In Ohio, the answer in all of these situations is that physicians *are not*

required to report physical or mental impairments to the BMV; disclosure of impairment is the burden of the license applicant. However, physicians may want to explain to certain patients the BMV's criteria for issuing restricted or limited licenses.

For example, the BMV asks applicants if they suffer from epilepsy or any other physical or mental impairment that would hinder their ability to drive, and asks for the name and address of their physician. If the applicant answers yes, the physician will be asked to complete a form regarding the patient's condition. A restricted license may be issued if, in the statement, the physician reports:

- The condition is under effective medical control
- The time period for which the control has been continuously maintained.

Physicians are not required to report impairments to the BMV.

After a restricted license expires, the registrar may issue an annual license if the applicant (who is not required to obtain a medical exam) submits a physician's signed statement indicating:

- The patient's condition is either dormant or under effective medical control
- The control has been maintained continuously for at least one year prior to the date on the application for renewal
- The patient can be depended upon to take the medication that controls the medical condition.

Another situation where a physician may have to attest to a patient's physical or mental competence is if the registrar determines that an applicant is addicted to drugs or alcohol. In that case, the applicant's driving privileges are suspended until a physician can attest that:

- The person has successfully completed a treatment/

Breast of chicken



3-oz. cooked serving of chicken breast

Best of pork



3-oz. cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.^{1,2*}

Compare pork with chicken^{1,2*}

| | Calories | Total Fat | Saturated Fatty Acids | Cholesterol |
|---|----------|-----------|-----------------------|-------------|
| Chicken Breast, skinless | 140 | 3.0 g | 0.9 g | 72 mg |
| Pork Tenderloin, trimmed | 139 | 4.1 g | 1.4 g | 67 mg |
| Pork Top Loin Roast (boneless), trimmed | 165 | 6.1 g | 2.2 g | 66 mg |
| Center Loin Chop, trimmed | 172 | 6.9 g | 2.5 g | 70 mg |
| Chicken Thigh, skinless | 178 | 9.2 g | 2.6 g | 81 mg |

*Table refers to 3-oz. cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.¹ According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.¹

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

Recommend

TODAY'S PORK

The Other White Meat®

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rehabilitation program

- The person, to the best of the physician's knowledge, has maintained a six-month period of sobriety from addiction to alcohol or controlled substances.

In any of these cases, the physician should not violate the AMA's ethical guidelines by disclosing patient information without the patient's consent (i.e. contacting the BMV on your own). If you are asked to attest to a patient's medical condition, a physician has a duty to determine within reasonable medical certainty that the patient's condition is under effective medical control.

Finally, if you do have a patient in your practice about whom you have reservations about being on the road, explain the BMV's restrictions to them and urge them to answer the application honestly and in full. ■

Update

Fraud hotline

The AMA has established a health-care fraud hotline, 1-(800) 262-3211, that physicians may call to report incidents of fraudulent billing practices, Medicare and home health-care fraud, kick-backs for referrals and other fraudulent practices. Hotline reports are passed on to the FBI for investigations. The FBI is also making agents available to medical associations who would like a speaker on health-care fraud. Carrie Waller at the AMA (312) 464-4076 is making arrangements for speakers.

Cincy Academy sued

The Academy of Medicine of Cincinnati has been named a defendant in a class action lawsuit that concerns a terminated group health plan that had been offered to members. The academy says it isn't liable for the plan's termination or for the failure of the plan to pay participants' claims, and instead has acted as advocate for those affected by the termination. The academy adds that it will vigorously defend itself in the suit that has been filed in U.S. District Court in the Eastern District of Kentucky.

Obtaining a Handicapped Parking Card A

To qualify for a handicapped parking card, a person must have permanent or temporary:

- loss of the use of one or both legs or arms
- handicap so severe that he/she cannot move without the aid of crutches, a wheelchair, cane, walker, leg braces, arm braces, back brace, neck brace or any other artificial aid required to move about
- blindness or deafness
- impaired mobility from permanent cardiovascular, pulmonary or some other handicapping condition

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for health insurance,

be sure to check

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to provide OSMA members,

and employees of OSMA members,

the best selection of benefits

at the best possible cost.

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Columbus, OH 43216-6182

Legal Notes

In Brief: This column is condensed from the OSMA's legal fact sheet notebook. You may want to cut and save this column for reference. Questions should be referred to the OSMA's Department of Legal Services.

Informed Consent

To be valid, consent must be informed and must be made voluntarily, by a competent patient. Information needs to be discussed with the patient accurately and in layperson's terms. The physician should describe the diagnosis and the proposed treatment, including possible risks, probability of successful outcome, the feasible alternatives and the risks of non-treatment.

A physician who fails to obtain informed consent may be found liable under the tort of lack of informed consent. Lack of informed consent exists when: a) the physician fails to disclose and discuss with the patient the material risks and dangers inherently and potentially involved; b) the unrevealed risks and dangers that should have been disclosed by the physician actually materialize and are the proximate cause of the injury to the patient; and c) a reasonable person in the position of the patient would have decided against the therapy had the material risks and dangers inherent to treatment been disclosed to him or her prior

to the therapy. (A risk is material if a reasonable person would find it significant in deciding whether or not to undergo the proposed treatment.) In Ohio, a patient's informed consent may be given orally or in writing. A written consent is valid if: 1) it states the nature and purpose of the procedure, the reasonably known risks, and the names of the physicians who will perform the procedure; 2) the patient acknowledges both disclosure of the information and that all questions have been satisfactorily answered, and; 3) the consent is signed by the patient or a person with legal authority to consent on behalf of the patient when the patient lacks legal capacity to consent. However, written consent is not valid if the consent was obtained through fraud or consent was not given in good faith.

COMPETENCY

Ohio law recognizes that circumstances may render the patient's consent impossible or

impractical to obtain. The presumption of capacity is overcome when either the patient has been legally determined to be incompetent or a guardian has been legally appointed to make decisions for the patient. In all other cases, the patient's competency must be specifically examined to overcome the presumption. Physicians should do a mental status examination to assess competency whenever the patient's behavior suggests a lack of capacity and the patient's decision is needed. Physicians should assess patients' capacities fairly and consistently and document in writing the reasons prompting assessment and the reasons supporting the conclusion reached.

If a patient has been determined to be incompetent, any of the following may authorize consent on behalf of the patient: 1) an attorney in fact if the patient has executed a durable power of attorney for health-care decisions; 2) a guardian, if the patient is a minor or judged incompetent; 3) a family member who, in good faith,

makes a decision consistent with either the patient's expressed wishes or with what the patient would have wanted.

The presumption of capacity is not necessarily overcome by the patient's residence in a mental institution. Consent must be obtained unless: 1) the chief clinical officer or attending physician concludes the patient is unable to receive the required information, physically or mentally; 2) the patient has been judged incompetent. Any resident of a nursing home has the right of informed consent unless the attending physician decides it isn't medically advisable to give the information to the patient.

PRESUMED OR IMPLIED CONSENT

There are also circumstances when the patient's consent will be presumed or implied. Nevertheless, a patient has the right to refuse treatment, and the refusal may not be overcome by the doctrine of presumed or implied consent.

\$30,000 BONUS OFFERED TO HEALTH CARE PROFESSIONALS

If you are a board-certified physician or a candidate for board certification in one of the following specialties, you may qualify for a bonus of up to \$30,000 in the Army Reserve.

Anesthesiology
General Surgery
Thoracic Surgery
Pediatric Surgery

Orthopedic Surgery
Colon-Rectal Surgery
Vascular Surgery
Neurosurgery

A test program is being conducted which offers a bonus to eligible physicians who reside in certain geographic areas (Pennsylvania, West Virginia, Ohio, Michigan,

Illinois, Indiana, Wisconsin, Minnesota and Iowa). You would receive a \$10,000 bonus for each year you serve as an Army Reserve physician—for a maximum of three years.

You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

To learn more about the Army Reserve and the Bonus Test Program, call one of our experienced Medical Personnel Counselors: **Call Collect 614-481-8858**

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Ombudsman answers CLIA questions

The OSMa Department of Ombudsman Services continues to receive inquiries regarding the CLIA '88 program. Some of the most frequently asked questions include:

Q. Do I need a CLIA number?

A. Physicians who perform even one clinical laboratory test must obtain either a two-year certificate of waiver, physician-performed microscopy certificate or a registration certificate. By now all physicians doing laboratory testing in their office should have received a CLIA number. Physicians who have not previously applied for a CLIA number may use HCFA forms 114 and 116 to apply.

Q. What type of certificate is needed?

A. The type of certificate is based on the highest level of testing performed. If a physician performs even one lab test that is not listed in the waived category or the physician-performed microscopy category, the physician must obtain a registration certificate rather than a certificate of waiver.

Q. What are the waived tests?

A. There are nine waived tests:

- Dipstick or tablet urinalysis (nonautomated)
- Fecal occult blood
- Ovulation tests using visual color comparisons
- Urine pregnancy tests using visual color comparisons
- Erythrocyte sedimentation rate
- Hemoglobin by copper sulfate method
- Spun microhematocrit
- Blood glucose using certain devices cleared by the Food and Drug Administration (FDA) specifically for home use

- Automated hemoglobin tests using single analyte instruments with self-reagent interaction and direction measurement and readout

Q. What is the cost if I perform only waived tests?

A. Physicians performing only waived tests must pay \$100 biannually for a waiver certificate and will not be subject to CLIA inspections.

Q. What are the physician-performed microscopy tests?

A. There are six physician-performed microscopy tests included in the CLIA regulations. Physicians performing them must pay \$150 biannually for a physician-performed certificate. The tests include:

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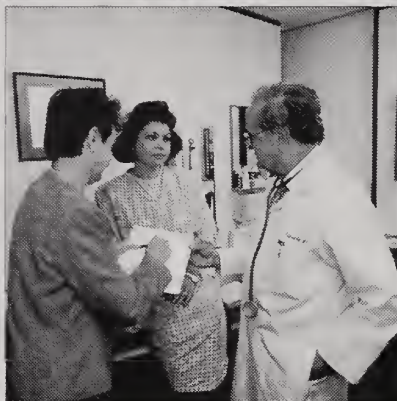
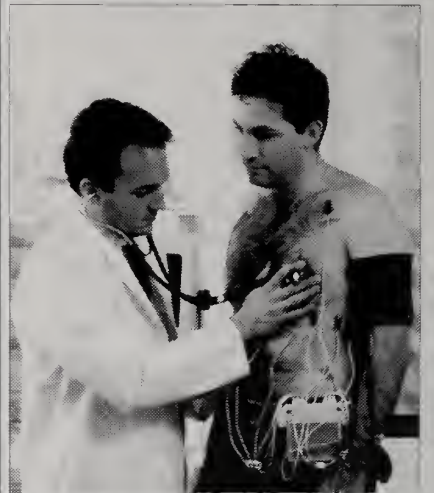
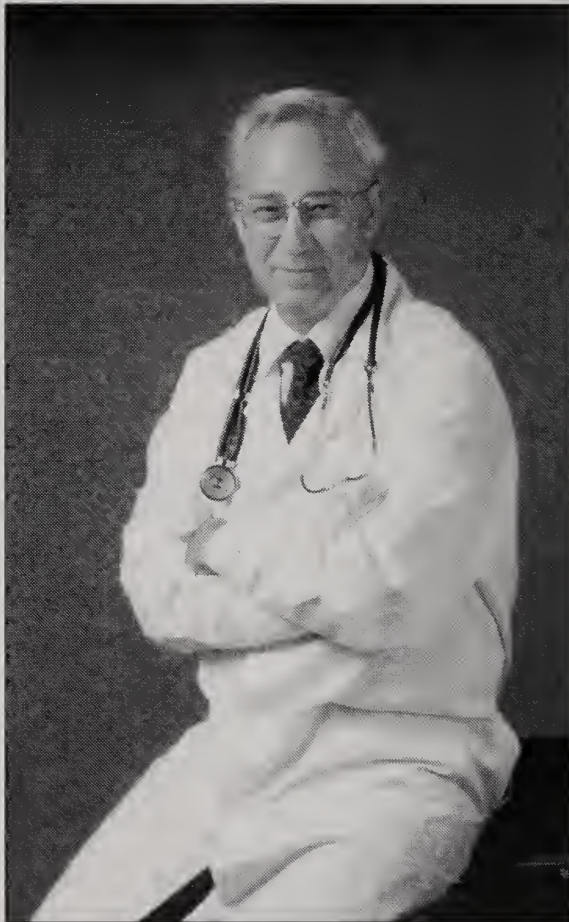
"After years of study, I honestly believed that I was ready to go into practice. I thought that knowledge and experience in medicine was all that I'd need to be a success out there. But, no one ever mentioned that I'd have to be an expert at insurance, law and collections...I'm a doctor, with a substantial amount of money and time invested in being the best that I can be. It didn't take long for me to realize that the time spent in managing my business was time taken away from the really important things in life; my patients, my family, and myself."

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"Kelsey-Seybold Clinic offered me a competitive salary, flexible benefit package, and a practice style to fit my goals and lifestyle. Within their multi-speciality group I found many options; fourteen urban/suburban clinics in Houston and several locations outside Texas. I decided to be a part of the Kelsey-Seybold family at The Texas Medical Center in Houston. It offered the kind of pace that I was looking for professionally, and put me right in the center of the most dynamic and fun city in the Southwest."

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Kelsey-Seybold Clinic currently has openings in selected specialties. Please call to learn if our style of practice is right for you. We will be happy to discuss our opportunities and answer your questions.



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Medical Towers, 18th Floor
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1-800-231-6421

HIRD-PARTY **UPDATE**

- Wet mounts, including preparations for vaginal, cervical or skin specimens
- KOH preparations
- Pinworm preparations
- Fern tests
- Urine sediment exams

- Postcoital exam

Q. When do you need to get a registration certificate?

- A.** Tests not falling into the waived or physician-performed categories require a biannual registration certi-

cate, which costs between \$100 and \$600. Offices doing this type of testing are subject to CLIA inspections, which run between \$300 and \$3,115.

Q. Who can I contact with questions?

- A.** You may either contact the OSMA Department of Ombudsman Services at 1-(800) 766-OSMA or HCFA-CLIA Program, P.O. Box 26679, Baltimore, MD, 31207-0479 or call (410) 290-3850. ■

Deadline nears for Workers' Comp

Time is running out. If you would still like to participate in the OSMA's Workers' Compensation group rating program you have until June 30.

The last two issues of *OHIO Medicine* have included the necessary forms that must be completed. If you missed those forms, contact the Association Consultants, Inc., which is assisting the OSMA and the Frank Gates Service Company with the group rating program. Call 1-(800) 777-4283, ext. 432.

If you are already a participant in the program, you don't need to reapply. ■

Update

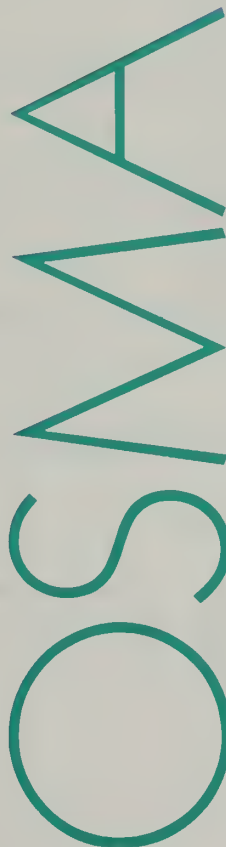
HMOs raise rates

Ohioans who must purchase health-care coverage on their own will see their premiums rise dramatically this month as HMOs raise their rates to open-enrollment, non-group members. The average premium will be raised by about 20%, although some rates will climb as much as 56%. The new rate affects about 10,000 Ohioans.

"Report card" issued

The Cleveland Health Quality Choice program has released its long-awaited "report card" that judges the quality of Cleveland-area hospitals. Local businesses will use the report when determining which area hospitals should receive their employees as patients. This year's report will provide a baseline for future reports, which program participants intend to release on a biannual basis.

Who knows better than other physicians what life and health insurance physicians need and what rates physicians are willing to pay?



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1992/1993 Laparoscopic Cholecystectomy Codes*

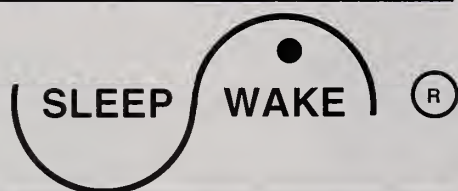
| OHIO LOCALITY | 1992 | | 1993 | |
|------------------|------------|------------|------------|------------|
| | 49310 | 49311 | 49310 | 49311 |
| 1 | \$1,168.15 | \$1,261.85 | \$1,064.94 | \$1,148.36 |
| 2 | 1,146.56 | 1,285.67 | 1,048.69 | 1,167.22 |
| 3 | 1,141.23 | 1,276.74 | 1,047.27 | 1,163.22 |
| 4 | 1,163.27 | 1,306.28 | 1,061.08 | 1,182.59 |
| 5 | 1,142.23 | 1,256.13 | 1,044.83 | 1,143.87 |
| 6 | 1,143.03 | 1,281.59 | 1,042.13 | 1,160.00 |
| 7 | 1,099.34 | 1,341.34 | 1,007.42 | 1,205.21 |
| 8 | 1,087.03 | 1,110.51 | 1,002.92 | 1,032.10 |
| 9 | 1,144.43 | 1,304.20 | 1,042.84 | 1,177.10 |
| 10 | 1,162.62 | 1,304.32 | 1,063.90 | 1,184.58 |
| 11 | 1,152.18 | 1,231.69 | 1,051.62 | 1,123.98 |
| 12 | 1,158.60 | 1,316.45 | 1,052.97 | 1,185.69 |
| 13 | 1,145.60 | 1,250.04 | 1,043.42 | 1,134.86 |
| 14 | 1,133.24 | 1,304.87 | 1,036.03 | 1,179.55 |
| 15 | 1,148.57 | 1,328.15 | 1,045.77 | 1,195.31 |

* These are the correct Medicare reimbursement levels for these procedures for 1992 and 1993; See related story on page 1.

A Good Night's Sleep Is Not A Luxury, It Is A Necessity!



Helmut S. Schmidt, MD, ABPN, ABSM
Dr. Schmidt, founder of the first Sleep Medicine Clinic in the Midwest to be accredited, directed the National Examination to certify Sleep Medicine Specialists from 1980-1991 and was the first president of the American Board of Sleep Medicine. Long-time contributor to sleep, he was awarded the Kleitman Prize in 1988, the highest award in Sleep Disorders Medicine.



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Billing changes for durable supplies

Physicians who bill durable medical supplies to Medicare may have already or will soon receive forms for a new supplier number from the Health Care Financing Administration. The forms, HCFA-192, should be completed and returned by the end of this month. New supplier identification numbers should be made available to physicians by August.

Then, beginning November 1, physicians must submit separate durable medical equipment (DME) claims with the new supplier number to one of four DME Regional Carriers. Ohio's carrier is Adminastar Federal, Inc., located in Indianapolis, Indiana. Supplies that are used by the patient in a physician's office will still be bundled into the payment for the office visit, but those the patient takes home (catheters, ostomy

supplies, surgical dressings, etc.) are billed separately.

HCFA hopes this new process for filing DME claims will reorganize reimbursement for DME and prevent fraud and abuse by suppliers. Expect more information and clarification on this matter from HCFA as the summer progresses.

So far, OSMA's major concern about the regionalization of Medicare claims processing of DME is that often two claims will be required to file for benefits — one for the office visit to the Ohio carrier, and an additional claim for the DME to the regional carrier.

If you have not received a form to obtain a new supplier number, contact National Supplier Clearinghouse (NSC), P.O. Box 100142, Columbia, SC 29202-3142 or call 1-(800) 851-3682. ■

New EMS board needs volunteers

The new EMS board for the state of Ohio needs your help.

One of its responsibilities under Amended Substitute Senate Bill 98 is the establishment of regional physician advisory boards in each of 10 designated health regions.

The board has recommended that each regional advisory board consist of at least three physicians (those boarded in emergency medicine, surgery and pediatrics are preferred) and a chair who is experienced and active in EMS issues. The regional boards will recommend protocols appropriate for their areas, as well as run reports and medical dispatch procedures. Members will also serve as medical advisers to squads without medical advisers, and identify problems and needs that interfere with the delivery of accepted standards of care within each region.



They will then recommend solutions to the state EMS board. Regional boards will communicate with each other, as well as the state board, and facilitate educational activities in the region. There is no compensation, except for expenses incurred in carrying out duties.

Physicians who may be interested in serving on a regional board should send a letter of interest and curriculum vitae to:

Linda Ishler
240 Parsons Avenue
P.O. Box 7167
Columbus, OH 43266-0563

For more information or answers to questions about the regional boards and their duties, contact:

Robert Felter, MD
Children's Hospital Medical
Center of Akron
1 Perkins Square
Akron, OH 44308

Regional EMS Boards

- Region 1** – Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, Warren
- Region 2** – Champaign, Clark, Darke, Greene, Miami, Shelby
- Region 3** – Allen, Auglaize, Hancock, Hardin, Logan, Mercer, Paulding, Putnam, VanWert
- Region 4** – Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, Wood,
- Region 5** – Delaware, Fairfield, Fayette, Franklin, Knox, Licking, Madison, Marion, Morrow, Pickaway, Pike, Ross, Scioto, Union, Wyandot
- Region 6** – Athens, Belmont, Coschocton, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Vinton, Washington
- Region 7** – Ashland, Carroll, Crawford, Holmes, Richland, Stark, Tuscarawas, Wayne
- Region 8** – Portage, Summit
- Region 9** – Cuyahoga, Geauga, Lake, Lorain, Medina,
- Region 10** – Ashtabula, Columbiana, Mahoning, Trumbull



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Women physicians form Cincy group

Three Cincinnati physicians have co-founded a local chapter of the American Medical Women's Association, the sixth such chapter to be formed in Ohio. Psychiatrist Paula Biren, MD, internist Jean

Siebenaler, MD and fertility specialist Jennifer Thie, MD are the three co-founders.

The new group hopes to promote more research and education about women's health issues; take tough

stands on social issues, including abortion and domestic violence; become vocal opponents to sexual harassment and discrimination in the medical profession; and assist career development for women medical students.

Of approximately 3,000 Cincinnati physicians about 500 are eli-

gible to join the new chapter – including about 300 of the 1,700 active members of the Academy of Medicine of Cincinnati. The academy does have a Women in Medicine committee, but the new group's founders say their group

The new group hopes to take tough stands on several issues.

will be more aggressive on issues than the academy group.

"The academy is supposed to represent all physicians," says Marsha Branison, MD, vice-chair of the academy's committee, in an article in the Cincinnati *Enquirer*. With political and social issues in health-care becoming increasingly prominent, the academy group believes they need to present a united front with all academy members on these matters – and not just espouse the distaff side.

"Another group would be more free to take sides," Dr. Branison says, adding, "I think there's room in the community for both types of groups." ■

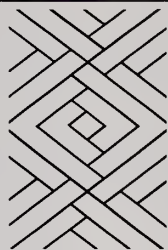
Leadership conference targets women, minorities

In hopes of building the future of family practice in Ohio, the Ohio Academy of Family Physicians sponsored an OAFP Leadership Conference specifically for new, women and minority members in early June at Kings Island Inn.

Each local chapter was encouraged to sponsor the attendance of three members – a new physician (in practice for less than seven years), a minority physician and a woman physician.

Organized by the OAFP New and Women Physicians Committee with help from the Minority Health Affairs Committee, the conference focused on the priorities of these three important groups of OAFP membership.

The keynote speaker was Robert Graham, MD, executive vice president of the American Academy of Family Physicians. ■



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Chiropractors team for ad campaign

How far will other health-care professionals go to promote their practices?

That question was answered to a certain extent this spring when Columbus chiropractors joined

forces and launched "Chirofirst," a media and advertising campaign, touting the benefits of chiropractic services.

Chiropractors agreed to pay \$300 per month for the media event that

began in April with 30-second television ads that aired over a dozen times daily on two local stations. Radio and print ads followed.

The campaign was designed to promote an around-the-clock telephone service that dispenses both information about chiropractic services and referrals, made by

geographic location.

"We're trying to provide...an economic alternative for (chiropractors) to access new patients," says Kristopher Keller, president of the Central Ohio Chiropractic Association in an article in *Business First*. ■

Forum topic: "Freedom in Medicine"

The second "Freedom in Medicine" conference was held this past spring in Dayton, and was supported by the Western Ohio Foundation for Medical Care.

The conference was organized to promote and strengthen the basic unit of medical care, and the doctor-patient relationship, while presenting opposing views of the current health-care debate.

Former AMA and World Medical Association President Edward Annis, MD, described the history of government intervention into medical care, including past attempts to socialize medicine.

Kent Masterson Brown, constitutional attorney and counsel for the Association of American Physicians and Surgeons, cited instances where government agencies, such as the Health Care Finance Administration, use harassment and intimidation and issue guidelines to those they regulate, even though no law governing these groups exist.

Managed competition was described by Dr. Merrill Matthews, director of the National Center for Policy Analysis, as a contradiction in terms, a euphemism designed to please both liberals and conservatives by combining government control with the term "competition," to give it a free market slant.

Robert Moffit, former deputy assistant secretary of HHS, noted that current health-care bills, such as the Rockefeller bill, include exemptions for members of Congress, their staffs, members of the executive branch, government agencies and the judiciary.

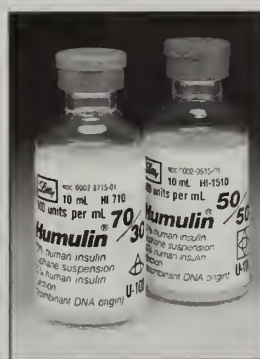
If you wish more information about the Freedom in Medicine seminars, contact N.M. Camardese, MD, 48 Linwood Ave., Norwalk, OH 44857. ■




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ANNUAL MEETING 1993



From left: Joe Murphy, MD, AMA-HMSS Governing Council; Michael Mishkind, MD; Khawwar Syed, MD; and James Wilkerson, MD, compare notes at the HMSS meeting.



As his family looks on, newly installed OSMA President Walter A. Reiling, Jr., MD, addresses the House of Delegates.



Rep. Patrick D. Sweeney (D-Cleveland) spoke at the annual OMPAC dinner.



Judy Lucas and her husband, outgoing OSMA President Stanley J. Lucas, MD, receive a past president's pin.



From left: Joseph Sudimack, Jr., MD, Walter A. Reiling, Jr., MD, and Stanley J. Lucas, MD, confer before the House of Delegates.



Charles Mueller, left, receives an award of recognition from Hospital Medical Staff Chair Lance Talmage, MD.



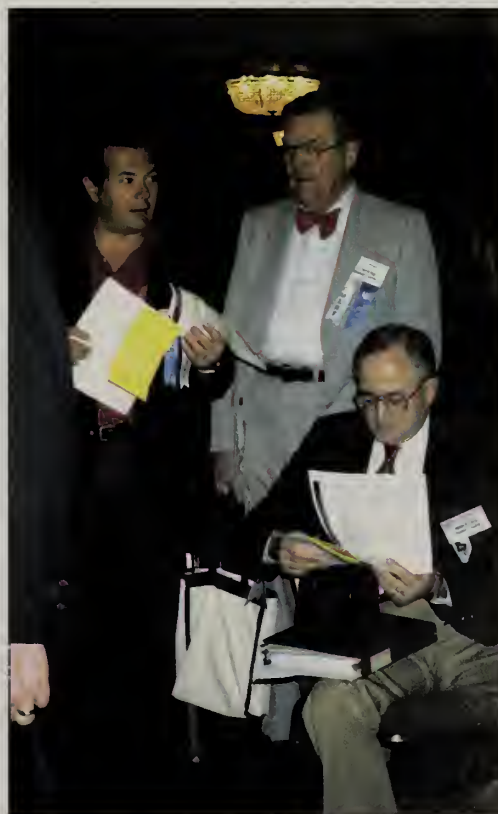
Daniel Santos, MD, left, and Lee Vesper, MD, listen to proceedings during the House of Delegates.



Attendees review the OSMA's family violence display during Annual Meeting.



From left: Victoria N. Ruff, MD, Claire V. Wolfe, MD, and Mary Jo Welker, MD, review meeting materials.



From left: James J. Barr, MD, Terrill Hay, MD, and Ralph Lach, MD, study resolutions.

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ORTHOPEDIC SURGEON – Lucrative partnership opportunity available to join established orthopedic surgeon in central Ohio. Excellent service area draw of 120K. Outstanding salary, partnership after two years and extensive benefits. Physician International, 1-(800) 846-0220.

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JOSEPH D. KIENER, MD, Columbus; Ohio State University College of Medicine, 1945; age 72; died February 28, 1993; member OSMA and AMA.

BERNARD S. MATTHEWS, MD, Lakewood; University of Cincinnati College of Medicine, 1944; age 74; died March 14, 1993; member OSMA and AMA.

HAROLD E. McDONALD, MD, Elyria; Case Western Reserve

University School of Medicine, 1944; age 72; died February 22, 1993; member OSMA and AMA.

BURTON G. MUST, SR., MD, Dayton; University of Cincinnati College of Medicine, 1934; age 86; died March 2, 1993; member OSMA and AMA.

JOHN R. POLLACK, MD, Newark; Universite de Paris VI, Paris, France, 1961; age 63; died March 3, 1993; member OSMA.

EDWARD M. ROONEY, DO, Cleveland; University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, 1952; aged 66; died March 7, 1993; member OSMA. ■

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News for Members of the Ohio State Medical Association

Cost to go up \$90 for two-year license

Legislature raises licensure fees

In Brief: Physicians' licensing fees have been set at \$250 – lower than the \$300 requested by the board – but higher than the figure the OSMA had wanted.

The good news is that physicians' licensing fees will not be raised to the \$300 figure requested by the Ohio State Medical Board. The bad news is Ohio physicians will see their license fees increase in the next biennium.

The license fee's roller coaster ride through the Ohio Legislature began early this year when the medical board asked to raise phy-

sician fees to \$300 as part of the state's two-year budget bill. The request represented a nearly 100% increase over the present \$160 fee. While the House was considering the board's request, board members approached the OSMA Council in an attempt to gain support for the hefty increase. Then-President Stanley Lucas, MD, let the board know, however, that the association would only support an increase if fees could be kept to no more than \$200.

SENATE RAISES FEES

The budget submitted by Gov.

George V. Voinovich in February did not increase the present \$160 fee. When the Democrat-controlled House passed the budget bill this spring, the licensing fees were raised to \$200. However, once the bill reached the Senate, that figure quickly escalated. The Republican-controlled Senate increased physicians' licensing fees to \$295 – nearly the figure that the Ohio State Medical Board had originally requested. The Senate stipulated that the fee should be broken down in the following manner: \$270 was

See **LICENSE** page 2

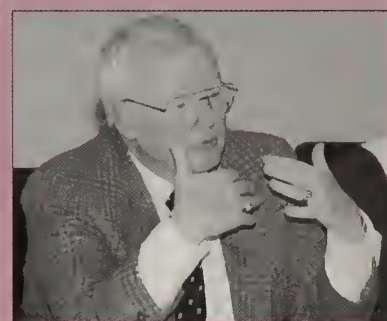
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■ **MEDICAID BILL:** The OSMA was successful in scaling back demands of nurses and physicians' assistants to expand their scope of practice. **3**

■ **STATE REFORM:** The new Ohio Health-Care Board expects to meet its January 1 deadline in making health-care reform proposals for the state. **6**

■ **RUNNING FOR OFFICE:** Drs. Ronald L. Price and Jack L. Summers have announced their candidacies for office of OSMA president-elect next May. **12**

■ **PHYSICIANS REIMBURSED:** Thanks to the efforts of two Ohio physicians and OSMA, physicians will be reimbursed from Railroad Medicare. **16**



Walter A. Reiling, Jr., MD

■ **CANDID SHOTS:** OSMA's new president talks about health-care reform, and how it will affect Ohio physicians. **20**

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SRF Correction

The question-and-answer column that appeared in the June issue of *OHIO Medicine* regarding the return of the Stabilization Reserve Fund (SRF) contained several errors of fact. Most notably there is no guaranteed minimum refund.

Please see the revised question-and-answer section on page 25. *OHIO Medicine* regrets the error.

OSMA stock sold to PICO

The Ohio State Medical Association completed the sale of its 36,000 Class B shares of the Physicians Insurance Company of Ohio to PICO on June 25.

PICO, in a move to strengthen its financial base, announced early last month that it would sell more than 1.4 million of its Class A shares to Quaker Holdings Limited, an investment company based in San Diego. PICO reported that the purchase price paid by Quaker Holdings will be \$5 million.

"We believe the transaction is in the best interests of the company's shareholders," says John E. Albers, MD, PICO's new president/CEO. "The infusion of capital further strengthens our financial base and will help maintain the company's presence in the marketplace." PICO presently holds a 26% share of Ohio's medical malpractice market.

In addition to the proposed transaction, Quaker Holdings, for

See **STOCK** page 2

Ohio Health Board Meets

Jackie Fullerton, center, executive director of the Ohio Health Care Board, takes a moment before a recent meeting to talk with Arnold R. Tompkins, director of the Ohio Department of Human Services, and OSMA President-Elect Claire Wolfe, MD, the board's physician representative.



Photo by Jack Kustron

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Dr. Sholtis Testifies

Carol Sholtis, MD, Gallipolis, testified recently before a House committee on House Bill 343, which would provide immunity to physicians who prescribe pain medication for terminally ill patients. Dr. Sholtis, representing the OSMA, spoke in favor of the legislation. (See related story on page 5.)

LICENSE...From page 1

to go to the board for operations and programs, and \$25 of the fees was to be used to help support the physician loan repayment program, established under House Bill 478, which encourages young physicians to stay and practice in underserved areas of the state by paying a portion of their medical school debt.

The Joint Budget Conference Committee split the difference between the House and Senate versions, settling on a \$250 figure. Twenty dollars of that total will be used for the physician loan repayment program.

MIXED FEELINGS

"As hard as we argued that an increase of this size is unwarranted," says John Van Doorn, director of OSMA's Department of Legislation, "Senate Republicans brushed aside those arguments and stood fast in their belief that physicians can afford to pay \$90 more for their medical license."

The OSMA also advocated that the entire amount of physicians'

license fees be returned to the board. This was satisfied partially by the creation of a special purpose fund into which the license fees of occupations will be deposited for their use.

Senate Republicans felt physicians could afford to pay \$90 more for their medical license.

"While there is no guarantee that all physician fees will be returned to the board, this new fund is better than having license fees deposited in a General Revenue fund," says Van Doorn.

See the Legislation section for more information on the budget bill. ■

STOCK...From page 1

a period of three years, will be entitled to purchase additional, newly issued Class A common shares of PICO, up to a total aggregate purchase price of \$5 million.

Now that OSMA has sold the Class B shares to PICO, the shares

will be retired prior to the closing of the proposed transaction with Quaker Holdings for the new Class A shares, PICO officials say.

As part of the sale, OSMA officers resigned from their positions on PICO's board of directors. ■

Surgeons and assistants entitled to more money

Just as many Ohio physicians expected, they had been insufficiently reimbursed from Nationwide-Medicare for laparoscopic cholecystectomies (CPT codes 49310 and 49311) performed during the past 18 months.

Now, *OHIO Medicine* has learned that those assistants at surgery in laparoscopic cholecystectomies are also entitled to more reimbursement, as well as physicians who performed laparoscopic cholecystectomy for enrollees of Travelers Railroad Retiree System and United Mine Workers Medicare Fund.

(For more information on the correct Medicare reimbursement levels for laparoscopic cholecystectomy procedures see the June issue of *OHIO Medicine*.)

Physicians wishing to receive reimbursement for assistant surgery need to make copies of their Explanation of Medical Benefits (EOMBs), highlight the claims to be reopened and include a cover letter requesting review and reopening to Nationwide-Medicare, Claims Operations, Attn. J. Bevens, P.O. Box 182195, Columbus, OH 43216. An amended claim must be filed for all non-assigned claims, where the limiting charge reported was lower than the new allowed limiting charge amount. These claims must also be bundled with a cover letter to Medicare.

Those physicians working with Travelers and United Mine Workers should submit a copy of their

Ohio Medicare EOMBs as an example of the correct allowable from Nationwide-Medicare, along with the EOMBs highlighting the incorrectly paid claims to those companies.

Recovering this reimbursement for Ohio physicians has been a tedious endeavor for the OSMA.

OSMA efforts have secured higher payment levels for lap choles.

Intensive lobbying by the OSMA's Department of Ombudsman Services to correct reimbursement levels for laparoscopic cholecystectomies resulted in HCFA advising Nationwide-Medicare to recalculate and reopen all claims from January 1992 to May 10, 1993. As a result, some Ohio physicians will receive double the amount of reimbursement originally received for the procedure. The physician's claims will be adjusted after Medicare receives a request from the physician.

If you need assistance, contact the OSMA Department of Ombudsman Services at 1-(800) 766-OSMA. ■

Dr. Albers to head PICO

John E. Albers, MD, Cincinnati, has been named chief executive officer and president of the Physicians Insurance Company of Ohio (PICO), making permanent the role of acting chief executive officer, which he assumed earlier this year. Dr. Albers will continue to serve as chair of PICO's board of directors as well.

A board-certified thoracic and cardiovascular surgeon, Dr. Albers has been associated with PICO for a number of years. Since 1985, he has been a member of the board, and has served on key board committees, including budget and finance, claims and underwriting.

In addition, Dr. Albers is a founding member and director of a

large health maintenance organization in Cincinnati, and is a founding member and officer of a medical peer review organization. Dr. Albers served as OSMA president from 1986-1987, and has been a member of the American Medical Association House of Delegates since 1978. ■



Dr. Albers

OSMA makes some gains on Medicaid reform bill

In Brief: Before the bill left the House, the OSMA was able to scale back those requests made by nurses and physicians' assistants to expand their scopes of practice.

The Medicaid reform bill, House Bill 183, has passed the House in a form slightly different from that reported last month.

The bill, sponsored by Rep. Paul Jones (D-Ravenna), has three major provisions of special interest to physicians – two seek to expand the scope of practice for two groups of allied practitioners, and a third establishes a Medicaid demonstration project in Butler County. Here is how the various provisions have shaped up:

PHYSICIANS' ASSISTANTS

Physicians' assistants have sought the right to be "institutionally employable," so that they might be hired by hospitals, as well as by physicians. They are also seeking prescription privileges, under physician supervision, and autonomy for their regulatory board.

In May, OSMA's House of Delegates adopted Emergency Resolution 02-93, which expressed disapproval of the expansion of PAs' scope of practice and directed the legislative department to try to defeat or modify these provisions.

So far, the OSMA has been mod-

erately successful in abating the PAs' requests. Their prescribing authority would not be independent but would be under physician supervision, limited to Schedule IV and V drugs, and permitted in health manpower shortage areas only. However, the House-passed

In Butler County, instead of compelling physicians to take their "fair share" of Medicaid patients, a board is to set up guidelines.

bill would allow PAs to be employed by institutions, eliminating Ohio's distinction as the last state to deny PAs hospital employment.

NURSES

Like the PAs, the nurses have also sought ability to prescribe drugs in collaboration with physicians. The OSMA has been successful in scaling back their request so that, in the House version, nurses may prescribe only Schedule III, IV and V drugs, under physician supervision and in health manpower shortage areas only. However, the OSMA's efforts will continue when the bill is presented to the Senate.

MEDICAID PROJECT

A provision in HB 183, suggested by Rep. Michael A. Fox (R-Hamilton), would create a Medicaid demonstration project in Butler County, where a board would be created to compel physicians to take their "fair share" of Medicaid

shortage area. The nurse and PA prescribing privileges would be decided by this new local board, which will have a majority of Butler County physicians as members.

"Dr. Ignatow and the Butler County Society are to be congratulated for their success in modifying this project," commented John Van Doorn, director of OSMA's Department of Legislation. "This is an excellent example of how local physicians, through active involvement, can improve legislation."

OHIO Medicine will continue to report on the progress of this bill as it makes its way through the Senate. ■

OSMA will meet with nurses, PAs

The OSMA will send its liaison committee to meet with the Ohio Nurses Association and the Ohio Osteopathic Association to discuss the nurse and physician assistant portions of House Bill 183.

OHIO Medicine will report on these meetings as they occur.

Budget bill passes with good, bad news for physicians

In Brief: License fees are raised and a third nurse pilot project is approved, but physicians will receive more Medicaid reimbursement.

Although the state budget bill emerged from the joint House-Senate committee increasing physicians' license fees to \$250 (see front page story), there was also some good news for physicians.

The bill approved an increase in Medicaid reimbursements, so that now an additional \$39.9 million will be earmarked over the next two years for those physicians who provide primary care services to Medicaid patients. However,

another part of the budget would place Medicaid patients in Butler, Franklin, Lucas and Hamilton counties under a primary-care case management system. The state hopes that this will help decrease Medicaid costs, while the increased reimbursements will encourage more physician participation.

ODH DIRECTOR

The OSMA also defended a statutory requirement that the director of the Ohio Department of Health be a physician. "The OSMA opposed the governor's attempt to repeal the physician requirement and we succeeded in eliminating it

in the House," says John Van Doorn, director of the OSMA Department of Legislation. The requirement never appeared in the Senate. "That's why we were astonished that it appeared again in the conference committee," he says. It now appears that the minimum credentials necessary for the ODH director will be a masters of public health degree.

NURSE PILOT PROJECT OK'D

A third nurse pilot project at the University of Cincinnati has been added to a program established under House Bill 478. The third

project would be in addition to two similar projects, under way in Cleveland and Dayton, that expand nurses' scope of practice to include prescribing privileges in collaboration with physicians. Another program was to be established in Columbus, but with the support of Franklin County physicians the OSMA lobbied to have that project removed.

The OSMA also opposed the Cincinnati project in accordance with the House of Delegates' policy. But OSMA efforts were undercut when the Cincinnati Academy of Medicine wrote that it didn't oppose the proposed project. ■

New law to prohibit paddling

After nine years, a Senate bill requiring Ohio public schools to consider eliminating corporal punishment has finally passed the General Assembly and will soon have local school boards rethinking

their corporal punishment policies.

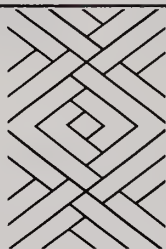
Senate Bill 29 requires any public school district that has not already eliminated corporal punishment to appoint a discipline task force (which would most likely include

physicians) to report on appropriate disciplinary measures for the district by July 15, 1994. After receiving the task force report, a local board of education would have to adopt a disciplinary policy (which may include corporal punishment if board members believe it is warranted).

However, as of September 1, 1994, paddling would be banned in those districts that didn't adopt corporal punishment as part of their disciplinary policy.

The House did adopt an amendment by Rep. Donald Mottley (R-West Carrollton) that permits districts to restore corporal punishment if alternative methods of discipline prove to be ineffective.

For years, the Ohio State Medical Association has had formal policy that calls for the elimination of corporal punishment in schools, and has actively supported this legislation. ■



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Mammography bill passes Ohio House

A bill requiring physicians to give patients a written copy of their mammography report upon the patient's request has passed the Ohio House. If it passes the Senate physicians will have to notify patients that they are entitled to a written report, either from their referring physician or the interpreting physician.

House Bill 215, sponsored by Rep. Randy Weston (D-Marion), originally called for physicians to also provide a copy of the X-ray film to the patient, but the OSMA was successful in removing that provision.

The OSMA has been working with the Ohio State Radiological Society to defeat the bill, since both groups believe it is unnecessary.

"Physicians' ethical guidelines say a copy or a summary of a report should be given to patients at their request," says John Van Doorn, director of OSMA's Department of Legislation. "Legislation mandating them to do so is unnecessary."

In a related development, a new state law takes affect this month, which requires health insurance to cover mammography screenings.

A cap of \$85 has been put on the procedure, however, and physicians as well as hospitals are prohibited from balance billing patients.

For more information on the limited charges for mammography screenings, please see the related story on page 16. ■

Doctors who provide pain medication may get immunity

In Brief: A new bill would provide immunity from prosecution to doctors who judiciously dispense pain medication to terminally ill patients.

Physicians who judiciously dispense pain medication to patients with terminal illnesses or who are in a permanent, vegetative state would be provided immunity from prosecution and professional discipline if House Bill 343 is passed.

The bill is sponsored by Rep. E.J. Thomas (R-Columbus), who introduced it at the suggestion of Warren Wheeler, MD, medical director for Hospice at Riverside in Columbus. Dr. Wheeler helped write the legislation.

Limited immunity would also be provided to other health-care professionals acting under a doctor's direction in dispensing the medicines – even if they appear to increase the patient's chances of dying.

BOARD POLICY

The Ohio State Medical Board (OSMB) has no written policy that guides physicians in prescribing pain medicine to patients with terminal illnesses, says Lauren Lubow, JD, spokesperson for the OSMB.

"It has generally been the opinion of the board that there will be no intrusion in this area," Lubow

states. "Physicians who prescribe pain medication for these patients are making the best out of a bad situation. The board wouldn't discipline or prosecute those involved."

The medical board has taken no position – at least not yet – on the bill. The OSMA, however, will actively support this legislation. ■

U.S. rep seeks to improve rural health care

U.S. Rep. Ted Strickland (D-Portsmouth), representing Ohio's sixth district, has joined with several colleagues in the U.S. House of Representatives Rural Health-Care Coalition to introduce a series of eight health-care bills. Here is a brief summary of what these bills, if passed, would do:

- allow states to apply for grants to enhance air medical transportation systems.
- provide exemption from Medicare's conditions of participation for isolated, small, rural hospitals.
- redefine criteria used in defining Health Professional Shortage Areas.
- allow primary-care physicians, practicing in rural areas, to deduct their student loan interest payments; allow primary care residents to defer payments on student loans until their residency is completed; and require Medicare to reimburse rural physicians in their first four years of practice at the same rate as other physicians.
- establish Medicaid demonstration projects to allow states to test innovative approaches for increasing Medicaid participation of obstetrical/gynecological providers in rural areas.
- reauthorize, for three years, the one-to-one matching grants to states for the establishment and operation of State Offices of Rural Health.
- allow, for three years, grants to small hospitals to develop better health-care services for their communities.
- permanently reauthorize the program that requires consortia of three or more entities in rural areas to provide health services in the community. ■

Assisted suicide bills put on hold

The flurry of bills introduced earlier this year when Jack Kevorkian announced his intentions to bring his particular brand of assisted suicide to Ohio have been stalled in House and Senate committees this session, and there was no last-minute push to move these bills out of committee before state legislators recessed for the summer.

When legislators return this fall, they will still need to consider House Bill 18, sponsored by Dale N. Van Vyven (R-Sharonville), and Senate Bill 7, sponsored by Sen. Grace L. Drake (R-Solon). These bills seek to prohibit assisted suicide in the state.

Workers' Comp bills stall in Legislature

In Brief: Although Workers' Comp reform legislation stalled, the OSMA has made progress in requiring the BWC to create a medical advisory committee to hear physician input.

The Ohio House and Senate failed to agree on a reform bill for the state's Workers' Comp system before the recess, which means that over the summer a joint conference committee will meet to negotiate over House Bill 107. Leading the negotiations will be Sen. Robert Cupp (R-Lima) and Rep. Ross Boggs (D-Andover), who chair the committees where Workers' Comp issues are decided in their respective houses.

House Bill 107 contains the two-year budget for the BWC and the Industrial Commission, as well as reform measures that earlier were considered as separate legislation. Because their budgets have not passed, the BWC and the commission are operating on interim budgets.

As in the past, the decisions about Workers' Comp reform were

being made by representatives of the business community and labor movement. This time, the OSMA insisted that physicians' views be considered, especially because these reforms are intended to control health-care costs.

OSMA GAINS PHYSICIAN "SEAT"

Labor and management agree that BWC needs managed care to better control its health-care costs. After initially arguing that BWC had already adopted several elements in managed care the OSMA has been advocating that physicians should be included in decision-making on these issues.

The OSMA succeeded in including physicians on two committees that will advise the bureau on managed care and other medical policies. In addition, the OSMA sustained the right to appeal BWC medical rules to a legislative body. "OSMA is pleased that physician voices will be heard by BWC policymakers," says John Van Doorn, director of the OSMA Department of Legislation. ■

Update

Living wills on licenses

Under a recently passed law, people with living wills or durable power of attorney for health care can now indicate they have made advance directive decisions on their driver's licenses or identification cards. They will be asked whether they have completed either legal document. If they have, a white sticker saying "Health Care Power of Atty., Ohio and/or Life-Sustaining Equipment" will be placed on the front of their license. The sticker will help ambulance and hospital staffs determine whether or not to use heroic measures to save or prolong life.

Patients who are interested in completing a living will or durable power of attorney can order their forms from the OSMA by sending their name and address, plus \$2 for each kit they wish to order to: OSMA, P.O. Box 931, Columbus, Ohio 43216-0931. Delivery takes four to six weeks.

HealthCare REFORM

What to expect in a national health reform plan

The Clinton proposal for a health-care reform plan may be issued this month. Then again, maybe it won't.

Reports of a July release date for the plan were announced, then there were rumors the date had been moved back to September. The White House followed these rumors with a statement that the plan would be released in July after all.

Whether or not the plan is released this month or later, the American Medical Association has prepared a list of certain reform elements that should be included in any successful plan. You may wish to keep this list handy so that you can evaluate the Clinton proposal – whenever it's released.

- **Universal Access** – Achieved through a combination of employer-required insurance,

Medicaid reform and insurance reforms. Included with this should be a standard employer-mandated health benefits package that includes preventive services, prescription benefits and unlimited physician office and home visits. Unlimited hospital days and expanded mental health services and hospice coverage should also be a part of the package.

- **Tort Reform** – A limit to contingency fees and noneconomic damages, a mandate to pay large awards on a periodic rather than lump-sum basis, and the creation of alternative means of resolving disputes.
- **Cost-Control** – Contain costs by reducing paperwork and other administrative factors.

Practice parameters and tort reform also contain costs. Global budgets, however, limit patient care, add to administrative costs and create new bureaucracies and should not be included in a reform package.

- **Insurance Reform** – Abolish pre-existing condition clauses and increased premiums due to health changes.
- **Quality Assurance** – Practice parameters, utilization review and risk management will eliminate the "black holes" where evaluation criteria are not disclosed to physicians. Also, more direct federal support for medical education, research and disease prevention would help.



- **Antitrust Relief** – Not exemption, but relief from antitrust laws so that physicians may be better able to negotiate with managed care plans.
- **Patient Freedom of Choice** – Patients should be free to choose their own physicians and retain the right to end the physician-patient relationship. Three kinds of insurance coverage should be provided to patients and their families: a benefit payment schedule, prepaid or usual, customary and reasonable. ■

Ohio health board recommendations expected on time

In Brief: The Ohio Health-Care Board is supposed to recommend a state health-system reform plan by January 1. Right now, everything looks like it's on schedule.

Even with the year now more than half over, Jackie Fullerton, executive director of the Ohio Health-Care Board, says recommendations for reforming Ohio's health-care system will definitely be ready for a January 1 deadline. Yet exactly what form those proposals will take is still in question. Claire Wolfe, MD, OSMA's president-elect – who serves as the physician representative on the board that was established last year under House Bill 478 – says it's not clear whether there will be detailed specifics presented, or only an outline.

SPECIFICS VS. GENERAL FRAME

Fullerton agrees. "I personally believe there will be specifics of things we'd like to do, then a more general outline of how we'll accomplish those things," she says.

Some of those specific items likely to be proposed in January, she continues, are a standard benefit

package for Ohioans, a universal claim form and possibly a tort reform proposal.

"I think we will present a combination of specific recommendations and a framework," says Fullerton. She points out that there are some health-care matters in the state that need immediate attention, such as the certificate-of-need program and Medicaid reform. Other items that might be recommended by the board, such as managed competition, will take some time to implement.

"Health-care reform in Ohio isn't going to happen overnight," Fullerton says. "I think it will take three to five years or even longer to put everything in place."

Right now, the board has clearly defined its role and its mission, and that is to make sure all Ohioans have access to health care. Board members have been divided into four working groups that have met regularly since spring to thrash out various aspects of health reform.

"We haven't reached that point, yet, where we have sat down as a board and debated the issues," says Dr. Wolfe. At press time, the com-

mittees were still gathering information, although some chairs had already assigned cut-off dates so their members could move on to the discussion stage.

INPUT STILL SOLICITED

That doesn't mean, however, that the board is no longer soliciting input from interested parties or members of the public.

"Many of the people who have written us to express concerns have been made members-at-large of our various committees," says Fullerton. Others have been invited to board meetings and committee meetings to talk, participate in discussions or lend technical support. The board will also be holding meetings at various locations around the state, and public hearings will be held at each.

"So far, I've been satisfied that medicine's voice is being heard, that we are having input into the process," says Dr. Wolfe.

Perhaps that's an especially reassuring point after the federal administration's deliberate move to include no representative of

organized medicine on its national health-reform task force.

Yet, like that task force, the state's health-care board also intends to move the health-care system away from one that treats disease and toward a system that focuses on prevention, wellness and life-style accountability.

"We're not going to wait for the Hillary Clinton task force report to begin shaping our own," says Fullerton. "Ohio was never going to wait for Washington. We have a governor who is eager to see health-care reform, so we intend to move ahead and move quickly."

Both Fullerton and Dr. Wolfe predict that, once the board releases its recommendations in January, the Ohio Legislature will move quickly to draft health-system reform legislation.

"At least, I hope they do," says Fullerton. ■



Clinical guidelines – friend or foe?

Editor's Note: Since practice parameters will almost certainly be a part of a health-reform package, OSMA's Legal Department has prepared this article on what constitutes good guidelines.

One aspect of health-care reform that concerns many physicians is the projected increase of the use of clinical guidelines in making diagnosis and treatment decisions. Physicians are not in agreement as to whether greater reliance on clinical guidelines is a good idea. Many doctors feel that use of clinical guidelines produces "cookbook" medicine, leaving the doctor with little independent decision-making authority.



GUIDELINES ALREADY IN USE

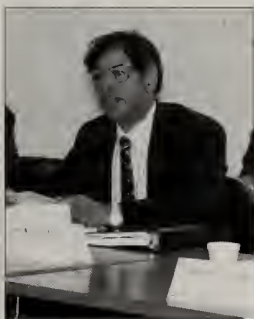
Whether you are for or against the development and use of clinical guidelines, they probably will affect your practice. As a matter of fact, they do now. Hundreds of clinical guidelines have already been developed by physicians in many specialties. Several specialties rely on guidelines applicable to specific clinical situations on a regular basis. Practice guidelines of varying forms have been around

for years. For example, the PRSO length-of-stay provisions were drafted more than 10 years ago. Other review criteria developed to help effect cost-control are also considered practice guidelines, although they focus on cost-containment rather than clinical situations. Hopefully, such guidelines will be based on more actual clinical data in the future.

With the passage of OBRA '89, which established the RBRVS, Congress recognized that volume-control, or medical necessity, as well as cost-control are important factors in reducing unnecessary medical spending. The RBRVS system is premised on the assessment of utilization needs. What is missing are statements on what is clinically necessary.

To remedy this situation, OBRA '89 established the Agency for Health-Care Policy Reform, which is charged with the task of developing clinically sound guidelines. AHCPR employs numerous methods to produce guidelines. Guidelines are developed within the public health system, sometimes under contract with non-governmental entities. The guidelines developed by AHCPR are not meant to be used solely as financial controls. They are intended to be

about the group and its mission to formulate a health-care reform plan for Ohio in a feature story located on pages 21-22. ■



Board member Unni P.K. Kumar, MD

OSMA health force meets this month

The OSMA's Task Force on Health-Care Reform continues to meet, and it anticipates having a full report ready for the membership by early this fall.

Member input is still being solicited, so if you have concerns you would like to see addressed, or information you would like to provide, contact one of the task force members as soon as possible.

The task force will meet again this month, July 17, at OSMA headquarters in Columbus.

Task force Chair Walter Reiling, MD, makes some observations

Attributes of Good Guidelines

(summarized from the AMA's *Attributes of Practice Parameters*)

1. **Validity** – When followed, they produce expected outcomes
2. **Reliability/Reproducibility** – Another group of experts would produce the same set, guidelines are interpreted and applied consistently in given circumstances.
3. **Clinical Applicability** – Appropriate definition of patient populations to which they pertain.
4. **Clinical Flexibility** – Identify known or generally expected exceptions.
5. **Clarity** – Unambiguous language, logical to follow
6. **Multidisciplinary Process** – Developed by a diverse group
7. **Scheduled Review**
8. **Documentation** – Evidence, assumptions and rationale available and meticulously described

sound clinical guides to be used by all practitioners and to apply across populations.

CHOOSING GUIDELINES

The biggest problem with all guidelines is deciding which ones to follow. The primary test of a good guideline is clinical applicability. The issue of cookbook medicine can be addressed by guidelines that contain clinical flexibility. The best guidelines will support a physician's decision to do or not to do something. Good guidelines are national in their scope. Local variation should not be a concern with guidelines that contain the requisite amount of clinical flexibility.

The American Medical Association has developed a system for evaluating the validity and effectiveness of guidelines (see above). The attributes of good guidelines, or practice parameters, as the AMA refers to them, provide a way to measure the validity of the guides. Guidelines that contain these attributes are meant to be used at the time of the clinical circumstance, or actual interaction between the physician and patient. Quality standards, such as PRO review criteria, are post-assessment tools. Even prior authorization requirements are medical review criteria and not the same as clinical guidelines. This is not to say, however, that clinical guidelines will not be used for retrospective re-

view purposes.

Rather than being used solely in the utilization review sense, practice guidelines may be used for retrospective review to determine whether the applicable standard of care was met. In some cases, the guidelines will formalize a standard of care. In others, the guidelines will be used to defend a decision not to comply with the standards set out in the guidelines because the clinical circumstances warranted non-adherence to the guideline.

THE FUTURE

It is very likely that clinical guidelines will become a significant part of health-care reform. In many circumstances they will benefit physicians. For instance, they may help standardize expert testimony on standard of care in some areas. This would ultimately save time and money as well as provide doctors with defenses in malpractice actions.

Guidelines may eventually give some indication of what a basic health-care benefits plan should look like. This is what guidelines do best; they clinically define what is and is not necessary in particular cases. Well-designed clinical guidelines will give physicians enough flexibility to make clinical determinations on a case-by-case basis, at the same time providing some protection from liability claims. ■

PRESIDENT'S PERSPECTIVES

What has the OSMA done for me?

I have been increasingly challenged by my fellow physicians who, knowing of my interest and involvement in the OSMA, ask, "What has the OSMA done for me?"

All physicians are currently under some degree of economic stress related to rapidly rising practice costs, accompanied by falling reimbursement. Prudence dictates a careful analysis of all practice expenditures, including organization dues. I truthfully believe my peers are asking a financial or economic question rather than a professional or philosophical one. They are simply asking me to defend value received for dues dollar spent. It is an honest and legitimate question. Physicians are no longer willing to join an organization for the sense of "belonging."

The fellowship appeal of medical organizations disappeared long ago. In short, all medical organizations, including the OSMA, must now be prepared to justify their existence on an economic basis.

Fortunately for me, it is rather easy to show that OSMA membership is a positive influence for most physicians' bottom line. Actually, I could supply many examples to prove my claim, but rather I would

Physicians are no longer willing to join an organization for the sense of "belonging."

like to cite four recent events to illustrate what OSMA activity has done for you.

1.) Legislative

During the final days of the drafting of HB 478, a proposal to tax all physicians' gross income 1%

was introduced. Rapid action by the OSMA legislative department helped defeat that proposal. Just estimate what that would have cost you annually and then compare it to your yearly dues. Statewide, physicians would have paid well over \$25 million in extra tax.

2.) SRF (Stabilization Reserve Fund)

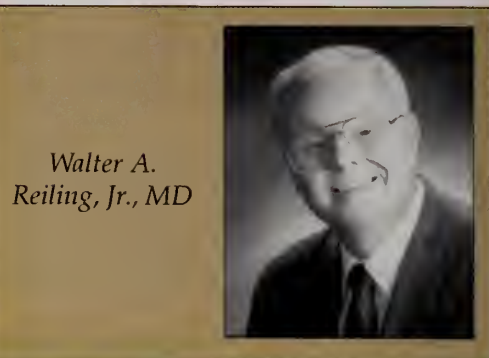
The OSMA helped sponsor legislation mandating the return of almost \$30 million to the physicians of Ohio.

3.) Medicare

Recently, the OSMA uncovered a serious mistake in reimbursement by Medicare for certain surgical procedures. At the behest of the OSMA, HCFA has directed significant additional concurrent and retroactive payments.

4.) Workers' Compensation

Many physicians have realized



Walter A. Reiling, Jr., MD

substantial savings by purchasing their Workers' Compensation insurance through the OSMA. For example, in my group of four surgeons, our annual savings pays our entire OSMA dues.

If I were to view the situation from the reverse perspective, I would legitimately ask, "How much worse would your practice finances be without the OSMA's constant vigil and prompt action?"

Your OSMA dues may be the most efficient and effective dollars you spend! ■

OHIO Medicine

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SECOND OPINION

An open letter to Sen. Howard Metzenbaum

Dear Senator Metzenbaum:

Following graduation from high school in 1971, I spent the next 14 years of my life preparing myself for the practice of medicine. During this time, I either paid tuition or earned a minimum wage for working 80-120 hours per week. Since coming back to Warren to start my private practice, I am gratified to say that my hard work paid off. I have earned the respect of my patients and colleagues and have a busy work schedule and an active public life. For reasons that are not clear to me, I have also earned the antipathy of my government, which apparently believes I am greedy and dishonest.

I did not complain when the Health Care Finance Administration (HCFA) regulated my laboratory (CLIA '88). I *did* complain when I found that the regulations included a \$300 tax to register, a \$500 tax for annual inspection, the need to compile a 75-page office manual, and required continued medical education courses, at my expense, specifically related to the testing I perform, even though I have been performing these simple office bedside tests for 15 years.

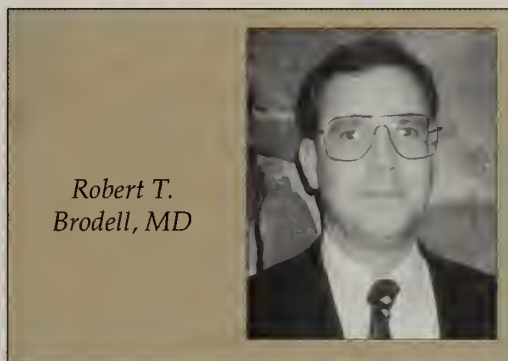
If the regulations are not amend-

ed, I will probably cease doing the dermatology tests required to practice good medicine next year. There is no alternative method for obtaining these tests.

I did not complain when OSHA took an interest in AIDS following the Kimberly Bergalis case. I *did* complain when, instead of targeting tattoo parlors, manicurists and non-medical personnel who may not know about AIDS, they targeted physicians and dentists. I now have spent 75 hours of my time and an equivalent amount of staff time compiling manuals and procedures that offer no more protection than I had prior to OSHA involvement. Across the country, this must have cost billions of dollars in time, and the oversight by OSHA will cost millions. Note, no further cases of AIDS transmission to patients have occurred anywhere in the country, before or after introduction of these burdensome rules.

I did not complain when I received a "Dear Supplier" letter from Medicare recently. I am not a medical supply company, I am a physician. I *am* complaining now that I realize that in the name of

controlling fraud, HCFA requires that I fill out ownership and control papers, report changes in this status, maintain complaint logs,



Robert T. Brodell, MD

reapply every three years, maintain inventory records, honor all warranties expressed or implied, answer questions about products under penalty of law, maintain and repair rental items, and accept returns of unsuitable items.

The materials I supply are wound dressings for elderly patients' leg ulcers. I never made a profit on these items. In an effort to avoid these regulations, I will need to see patients in my office, send them out to a pharmacy to pick up the dressings, and then return with them to my office for instruction. This is a ridiculous burden on the

elderly patient and on the smooth operation of my office.

How did these things happen? Clearly regulations were made without consultations with clinical physicians. Any clinical physician knows how to perform bedside tests. Any clinical physician knows the importance of universal precautions for AIDS and the protection of self, family and patients. Any physician knows that dispensing dressing for ulcers in an office is not an invitation to fraud. Now, we are told that Hillary Clinton does not believe doctors belong at the table in discussions of a new health-care system. That worries me. Physicians have been the primary advocate for patients for 2,000 years.

Please try to help. My office is open to you at any time you might wish to inspect it or discuss these issues with me. I would also be happy to visit your office.

Sincerely,

Robert T. Brodell, MD
Cincinnati

(This letter also appeared in the Ohio Dermatological Association's publication.) ■

LETTERS TO THE EDITOR

More on the proposed license increase

To the Editor:

I oppose the proposed increase in physician license fees. I am a primary care physician in internal medicine. I have been strangled by ever increasing overhead costs and ever dwindling reimbursement. I simply cannot afford additional financial demands.

DONALD E. BENSON, MD
Cincinnati

To the Editor:

I wholeheartedly agree with Drs. Richards and Hess regarding the license fee increase. (Letters to the Editor, May issue, *OHIO Medicine*.)

I believe there is absolutely no reason to increase the fee. Even \$100 is more than enough.

M. WAJID SIDDIQI, MD
Dayton

News & Views

Routine tests

An article in *Pediatrics* gave evidence that routinely testing for anemia in well infants and children is an unnecessary procedure, not only in the sparsity of findings, but also in discomfort and costs.

I suspect that many of us hoary pediatricians and family doctors came to that conclusion long ago, as we learned from experience that many routines, and just that – routines – do nothing but add to medical costs.

Long ago I stopped the routine one-year, well-baby hemoglobin determination, unless I suspected

a problem from my history or physical exam. I've yet to regret my decision. Have you made any similar decisions that you do or do not regret?

W.B. Rogers, MD
Cuyahoga Falls

Do you have a comment about something you've read or an opinion you'd like to share with your colleagues? Write to:

Editor, *OHIO Medicine*
1500 Lake Shore Dr.
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ALLIANCE REPORT

The challenges of change

The Challenge of Change, the courage to forge ahead with new ideas – not uncertainty, but progression – that is what the members of the Ohio State Medical Association Auxiliary faced and achieved at their annual convention when they voted to adopt the name of Alliance.

We had a need for the name of our organization to appeal and appropriately apply to our diverse constituency. Fifty years ago, we were known as the Women's Auxiliary. Obviously, this would not be appropriate or politically correct today as we embrace in our membership male spouses of physicians. Now we are male, female, full-time homemakers, career and professional workers. In addition to the volunteer hours given to the alliance, we are also giving volun-

teer time to our church, school and community organizations. These new changes require new approaches. With less time to devote to volunteering, we look for an

We had a need for the name of our organization to appeal to our diverse constituency.

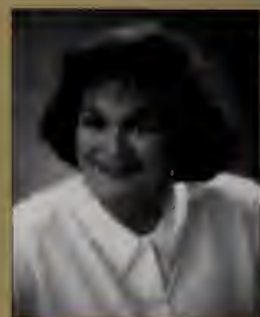
organization with a sense of purpose.

We have developed and achieved a working relationship with the

medical society. We have become "partners with medicine." In order to reflect the evolution of our members, our focus and goals, the tagline, "Physicians' spouses dedicated to the health of America," was also adopted.

The purpose of the name change has been best explained by the past president of the AMA-Auxiliary, Sherry Strebel: "While what an organization does may be more important than what it is called, the name must be consistent with people's perception of the organization's purpose. If a name projects no identity, the wrong identity, a mixed message or is outmoded, it affects the way the organization is perceived. So, as a communications

Valerie Vollmer,
President



device that describes what an organization is and does, a name plays a vital role in membership and other concerns."

This is an exciting time for the Alliance and medicine. We are now officially recognized as the Ohio State Medical Association Alliance – Physicians' Spouses Dedicated to the Health of America. ■



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Photo by Ted Grudzinski



Ohio Delegates Take Resolutions to AMA

James S. Todd, MD, (left) executive vice president of the AMA, and Ted Castele, MD, chair of the Ohio delegation, meet at the AMA's 1993 AMA Annual Meeting held in Chicago in June. The Ohio delegates brought five resolutions, which included a resolution discouraging the immigration of HIV-positive individuals to the U.S., and another calling for smoke-free environments in schools.

Verification service attracting IMGs

Applying for a state medical license or for hospital privileges can be a time-consuming task for any physician. But if you're an international medical graduate, gathering the necessary information from a medical school in a foreign country can prove daunting.

But now, more and more physicians – particularly IMGs – are taking advantage of the AMA's National Physicians Credential Verification Service (NCVS), which federal law named late last year as a principal resource in helping qualified IMGs gain U.S. licensure.

The program is not a credentialing service but a verifier of qualifications used when making credentialing decisions. A physician interested in the service first fills out a sign-up kit, which includes personal history, education, licenses

and specialty board certifications, medical society membership and employment history. The AMA then verifies this information through primary sources, which can take 45-60 days.

This information can then be sent, at the physician's request via a signed released form, to hospitals, medical boards or others. The AMA currently has 1,000 entities that accept its physician portfolios, including the Ohio State Medical Board.

Physicians wishing to use the service should contact the AMA at 1-(800) 677-NCVS. For a one-time nominal fee (AMA members receive a 50% discount) the AMA provides the original portfolio, plus unlimited updates for the physician's professional career. ■

OSMA In Action

A round-up of the association's activities...

■ Dr. Richardson Receives Sports Medicine Award

Delphis C. Richardson, MD, of Columbus, (left), outgoing chair of the Joint Advisory Committee on Sports Medicine of OSMA, Ohio High School Athletic Association, and Ohio Athletic Trainers Association, received a special award for Outstanding Service to Sports Medicine in Ohio from Henry D. Rocco, MD, of Newark, new chair of the committee. Dr. Richardson served four years as chair, and a total of 12 years as a committee member. He is moving to Phoenix, where he will join a pediatrics practice group.



■ Dr. Bixel Chairs DUR Board

Janet Bixel, MD, Worthington, has been elected chair of the Ohio Department of Human Services' Drug Utilization Review Board, an eight-member group responsible for reviewing and recommending standards to be used in prescribing drugs for Medicaid patients.

Currently, the board's goal is to persuade physicians to prescribe lower-cost drugs, and informational packets are now being developed to educate physicians on the cost of drugs and how prices can be reduced without sacrificing quality care.

Quality care is also the reason for the intervention letters the board may periodically send your office. "Many times, Medicaid patients are going to several doctors and several pharmacies, taking lots of different kinds of drugs without their physician's knowledge," says Dr. Bixel. The intervention letters provide information about the patient's additional prescriptions, and she urges physicians to respond to them promptly.

■ Ohio Team Physicians Honored

Outstanding Team Physician Awards will be presented for the 19th consecutive year by members of the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, Ohio High School Athletic Association, and the Ohio Athletic Trainers Association July 15 at the Four Winds Restaurant in Canton during the Ohio High School Football Coaches Association Hall of Fame Banquet.

Those to be honored include: Robert J. Herman, MD, Wapakoneta; Robert R. Roberts, MD,

Akron; Charles D. Stienecker, MD, Wapakoneta; Karl F. Wieneke, Jr., MD, Youngstown; and V. George Zochowski, DO, Pataskala.

■ Domestic Violence Campaign Wins Awards

Last month *OHIO Medicine* reported that the OSMA's domestic violence campaign, the Ohio Physicians' Domestic Violence Prevention Project, won an international award from the International Association of Business Communicators.

The campaign picked up three additional awards in June. A Bronze Quill award was received from the International Association of Business Communicators, Columbus chapter, a Prism Award from the Public Relations Society of America, Columbus chapter, and one from the Ohio Division of American Trauma Society through the Ohio Domestic Violence Coalition.

The coalition award honored individuals in three areas: legal, psychosocial and health/medical.

Drs. Price, Summers running for OSMA president-elect

Ronald L. Price, MD, and Jack L. Summers, MD, have tossed their hats into the political circle. At the OSMA Council meeting following the 1993 House of Delegates, Drs. Price and Summers announced

their candidacies for OSMA president-elect in 1994.

Dr. Price, a Fifth District Councilor, has been an active member of the OSMA for a number of years, serving as an OSMA alternate dele-

gate and delegate, a member of the Committee on State Legislation and an alternate delegate to the AMA. He also served as president of the Academy of Medicine of Cleveland.

A native of Pittsburgh, he graduated from Oberlin College, received his MD from



Dr. Price

Columbia University College of Physicians and Surgeons and completed postgraduate work at Health Center Hospitals of the University of Pittsburgh, the University of Louisville and the Children's Hospital National Medical Center of Washington, D.C. After 20 years as a pediatric ophthalmologist at the Cleveland Clinic Foundation, he's now in private practice at Case Western Reserve University.



Dr. Summers

Dr. Summers has a long and active involvement in professional associations, listing more than a dozen in which he holds professional membership. While he has served on numerous committees affiliated with these organizations, he has been an active member of the OSMA.

He has served as delegate to the OSMA. He was recently re-elected to a two-year term as alternate delegate to the AMA. He has served as District 12 Councilor and as president of the Summit County Medical Society and is a member of the Ohio Medical Political Action Committee.

Dr. Summers completed his undergraduate and medical studies at West Virginia University. He moved to Akron City Hospital where he served his internship and residency in general surgery.

He presently has a private practice in urology in Akron. In 1987, he received a PhD in human sexuality at the Institute for Advanced Study of Human Sexuality. He also has been certified as a sex educator by the American Association of Sex Educators and is board-certified by the American Board of Sexology. ■

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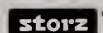
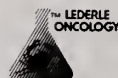
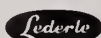
patient enrollment form. Data from this enrollment form will generate a prescription for the physician to review, sign, and give to the patient. The patient's pharmacist will dispense the medication to the patient and be reimbursed as with other third-party pay prescriptions.

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CALENDAR

The OSMA, in association with Conomikes and Associates, Inc., has planned the following practice management workshops for 1993.

Medical Office Management Institute (MOMI)

These workshops have been designed for medical office managers, supervisors and key employees. Some offices have used these workshops to upgrade the skills of established personnel as well as for indoctrination of new employees. The following five-day workshops can be taken in any combination:

- effective personnel management techniques;
- improving your managerial effectiveness;
- patient flow management;
- financial management;
- improving your third-party reimbursement and coding.

August 2-6, Cincinnati Kings Island Inn, Kings Island, Ohio

Young Physicians – Practice Management Seminars

Winning Investment Strategies for the '90s and Beyond – A half-day financial planning workshop teaching the principles of investing, and ways to apply these principles to your own portfolio.

Financial Control of Your Practice in 30 Minutes a Day – This two-hour workshop outlines steps participants can take to gain control over their finances without sacrificing time with patients.

Sept. 21 Holiday Inn, Worthington
 Sept. 22 Marriott Airport, Cleveland
 Sept. 23 Youngstown Club, Youngstown

How to Run a More Profitable Practice

This one-day workshop is designed to show you the steps to a smarter, leaner and more profitable practice. Learn where your trouble spots are and how to bring them under control.

Sept. 28 Marriott Airport, Cleveland
 Sept. 29 Concourse Hotel, Columbus
 Sept. 30 Marriott, Cincinnati

Maximizing Your Collection Results

This one-day course is designed for the experienced office manager, billing supervisor and physician manager. The course deals with all aspects of the collection process. Learn to identify the problem, correct it and make certain it doesn't return. The workshop approaches the collections function from the management perspective.

Oct. 12 Dana Center at MCO/Hilton, Toledo
 Oct. 13 Sheraton City Center, Cleveland
 Oct. 14 Parke Hotel, Canton
 Oct. 26 Concourse Hotel, Columbus
 Oct. 27 Stouffers, Dayton
 Oct. 28 Sheraton, Springdale, Cincinnati

OSMA elects three new councilors

Three new district councilors were elected at this year's Annual Meeting.

Mary Jo Welker, MD, Columbus, is the new Tenth District Councilor, replacing Claire Wolfe, MD.

Dr. Welker has a full-time family practice, and this year she will combine her role as OSMA Councilor with her new position as president-elect of the Ohio Academy of Family Physicians. She also serves on the Marketing and Public Relations Committee of the American Academy of Family Physicians.



Dr. Peter

Charles Peter, MD, Akron, is the new Twelfth District Councilor, replacing Jack Summers, MD.



Dr. Utlak

Dr. Peter is an ophthalmologist in private practice who has served as a Councilor, a regional coordinator, and a state affairs committee member for the American Academy of Ophthalmology. He has also served on the Board of Governors of the Ohio Ophthalmological Society and as president of the Summit County Medical Society.

David J. Utlak, MD, Canton, is the new Sixth District Councilor, replacing retiring Councilor Robert Reed, MD.

A cardiologist in private practice, he has served as president and board of trustees member of the Stark County Medical Society. He also served as president of the Canton Academy of Medicine and as an alternate delegate to the AMA.

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KNOWLEDGEABLE

Resolutions for the 1994 Annual Meeting

Editor's Note: The OSMA Constitution and Bylaws requires that we publish resolutions that will affect the Constitution and Bylaws.

Ohio State Medical Association House of Delegates

Introduced by: OSMA Council

Subject: Medical Student Representative on the Ohio Delegation to the AMA

WHEREAS, In 1986 the Ohio State Medical Association (OSMA) Bylaws were amended to provide for a medical student alternate delegate to the American Medical Association (AMA) House of Delegates; and

WHEREAS, The medical student AMA membership has decreased from 3,263 members in 1991 to 846 members in 1992; and

WHEREAS, The medical student Ohio membership has decreased from 3,266 in 1991 to 530 in 1992; and

WHEREAS, The Ohio delegation to the AMA is in the midst of being reduced from 18 delegates in 1991 to 13 delegates in 1994 and from 15 alternate delegates in 1991 to 13 alternate delegates in 1994; and

WHEREAS, The number of dues-paying OSMA members has increased from 11,568 in 1991 to 11,705 in 1992; **therefore be it**

RESOLVED, That the OSMA Bylaws be amended by deletion as follows:

CHAPTER 4 THE HOUSE OF DELEGATES

Section 9, Delegates to the American Medical Association. The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body, ~~except for one (1) alternate delegate who shall be elected by the medical student section in accordance with the constitution and bylaws of this association and the bylaws of the medical student section.~~

Introduced by: OSMA Council
Subject: OSMA Auxiliary Representative Become Voting Member of Council

WHEREAS, The Ohio State Medical Association Auxiliary (OSMA-A) president attends and reports to all OSMA Council meetings with no vote; and

WHEREAS, The 500 medical students in Ohio have a student representative and the 1,050 resident physicians have a voting representative; and

WHEREAS, The OSMA Auxiliary president represents more than 3,500 physician spouses of Ohio; and

WHEREAS, The OSMA Auxiliary actively participates in community health education projects, supports the passage of favorable health legislation and raises funds for AMA-ERF; and **therefore be it**

RESOLVED, That the OSMA amend Chapter 7 THE COUNCIL Section 4. INDIVIDUAL DUTIES OF COUNCILORS. ADD The duties of the Councilor representing the Auxiliary shall be to represent the Auxiliary to Council.

CHAPTER 5 NOMINATION AND ELECTION OF OFFICERS

Section 5, Nomination of Officers and of Delegates and Alternate Delegates to the American Medical Association. The report of the Committee on Nominations with respect to all offices, except that of president-elect, and with respect to all delegates and alternate delegates to the American Medical Association, ~~except for the alternate delegate elected by the medical student section,~~ shall be posted or distributed prior to the election. Nominations for the office of president-elect may be made from the floor at the Final Session of the House of Delegates. Each nominating speech for any one office shall be limited to three (3) minutes. Not more than one (1) speech shall be made in seconding a given nomination and such seconding speech shall be limited to one (1) minute.

Section 7, Election of Officers and of Delegates and Alternate Delegates to the American Medical Association (Paragraph 1). If there is more than one (1) nominee for an office, the election of officers of this association and of delegates and alternate delegates to the American Medical Association shall be by ballot. ~~Election of one (1) alternate delegate to the American Medical Association by the OSMA Medical Student Section shall be in accordance with the bylaws of the Medical Student Section.~~

CHAPTER 8 DELEGATES AND ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION (AMA)

Section 6, Terms of Office for Medical Student Section Alternate Delegate. ~~The alternate delegate elected by the Medical Student Section shall serve for a period of one (1) year from the time of election. The alternate delegate shall be eligible for re-election so long as medical student status is maintained;~~ AND BE IT FURTHER

RESOLVED, That this action take effect immediately for the 1994 OSMA House of Delegates elections regarding the 1995 alternate delegate allocation.

Survey results:

1). In the following states, the auxiliary president has a vote on the highest policymaking body of the medical association.

California – Auxiliary president has vote on board of trustees.

New York – Auxiliary president has vote on Council.

North Carolina – Auxiliary president has vote on Council.

Washington – Auxiliary president has vote on board of directors.

West Virginia – Auxiliary president has vote on board of trustees.

2). In the following states, the auxiliary president has no vote on the highest policymaking body, but has a vote on all committees:

Florida, Indiana, Illinois, Iowa, Michigan, Minnesota, Oklahoma, Tennessee, Texas

3). The following states were called and messages left. No answers as of November 5, 1992:

Georgia, Maryland, Missouri, Wisconsin

Fiscal Note: \$0

OSMA endorses electronic network

In response to the increasing number of OSMA members who are making the switch to electronic claims filing, the OSMA has endorsed an electronic data interchange network that provides this service to physicians. In May, the OSMA signed an agreement with the ProviderLink network to make its services available to OSMA members.

"The ProviderLink network is an electronic data interchange network that streamlines communications between providers and payors," says Lyn Flanagan, ProviderLink manager. The network is a product of United HealthCare Corporation, the owner of two of Ohio's largest health benefits providers, the Columbus-based PHP, and Western Ohio in Dayton.

Physicians can access the ProviderLink network in four ways: through their practice's present computer system; through an IBM or compatible PC, running the ProviderLink software; through a ProviderLink mini-terminal; or through a touch-tone phone.

To file a claim, the physician's office staffperson enters all the claim information directly into the computer system, pushes a button, and the claim is electronically routed to the appropriate payor, ensuring faster payments and substantially reducing the amount of staff time currently spent on filling out paperwork.

FASTER COMMUNICATIONS

In addition to electronic claims entry and submission, ProviderLink can also provide physicians' offices with such services as immediate patient eligibility verification; claims status checks; file transfer between physician offices and hospitals, or other physician offices; physician referrals; and referral status checks.

Jerry J. Campbell, director of OSMA's Department of Development and Member Services, points out that the ProviderLink network will also be used by the OSMA to streamline its communications with members by providing electronic messages whenever possible.

"We can send electronic messages and vital information to our members more quickly through

ProviderLink than through the mail," he says. With health-care reform issues promising to heat up soon on both the state and federal levels, this may be one of the best reasons to link up to the network.

For more information about ProviderLink installations in central, northeast and southeast Ohio, contact PHP's Lyn Flanagan at (614) 442-7220 or 1-(800) 328-8835, ext. 7220. If your office is in the greater Dayton area, call Western Ohio's Cheryl Sullivan at (513) 436-8857 or 1-(800) 644-5465. ■

Correction

In the May issue of *OHIO Medicine* in a feature on OSMA's Up-and-Coming Movers and Shakers Denise L. Bobovnyik, MD, should have been identified as chair of the Mahoning County Young Physician's Committee.

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Physicians' concerns over Railroad Medicare addressed

Thanks to the efforts of two physicians and the OSMA Department of Ombudsman Services, Ohio physicians who have been frustrated with the claims administration and adjudication practices of the Travelers Insurance Railroad Retiree system, located in Augusta, Georgia, may soon receive some satisfaction.

According to Bill Fry, director of the OSMA Department of Om-

budsman Services, Travelers Insurance Company is rarely up to date on current Medicare fee allowables, and frequently pays reimbursements that are lower than Nationwide-Medicare's current schedule amounts. By law they are required to reimburse at Ohio fee levels.

Yet, even when physicians brought these inconsistencies to Travelers' attention, they rarely received a response.

OSMA INTERCEDES

A few months ago, the OSMA interceded on behalf of Ohio physicians by sending a letter to the Health Care Financing Administration (HCFA) outlining the problems. HCFA in return forwarded the complaint to the Railroad Retirement Board in Chicago. The board then assigned an interim ombudsman to look into the matter for Ohio physicians.

Homer Williams, MD, Columbus, is an example of one Ohio physician who is grateful for OSMA's efforts. As a result of Railroad's consequent investigation, Dr. Williams recently received a \$200 check from Travelers. "Doctors don't deserve to be ripped off," he says. "It bothers me. I keep a very tight rein on what goes on

See next page

An update on mammography's new limited charge

On July 1, a provision of House Bill 142 – the mammography screening bill that was passed last year – became effective. This provision mandates insurers to cover screening mammograms and sets a cap of \$85 on the procedure. Balance billing is not permitted.

The OSMA has received a number of reimbursement questions on this matter. Below are some of the most frequently asked questions and answers.

Q. When does the \$85 charge limitation become effective?

A. The sections of the bill that deal with screening mammographies became effective July 1, 1993. Those sections that pertain to cytologic screenings became effective January 1, 1993. Also effective July 1 is a provision that states that no benefit for screening mammographies shall exceed \$85. This includes a statement that prohibits balance billing by "institutional and professional health-care providers for screening mammograms." There is no delay date on this provision.

Q. How should physicians who interpret screening mammograms within a hospital bill for the procedure now?

A. It would be wise for these physicians to reach an accommodation with the hospital concerning the "who's," "hows" and "wherefores" of

billing for screening mammography services performed within the hospital. Without such an agreement, it's likely that the first one to bill (be it hospital or physician) will be paid and the second one will either receive only partial payment or no payment at all.

Q. Should physicians consider the \$85 cap to apply only to the technical component, and feel free to bill the patient their usual professional fee for interpreting screening mammograms?

A. No. The Ohio Legislature definitely intended for the \$85 to be the total cost for mammography screenings. Physicians are expressly limited from billing for any part of the screening mammography service by the language contained in the bill. If you are aware of any hospitals that are encouraging physicians to balance bill their patients, please notify the OSMA's Legislative Department.

Q. Does the bill affect mobile mammography units?

A. The language of the bill does include mammography units. This means that coverage for mobile mammography services will also be limited by the \$85 cap and by the prohibition on balance billing.

Q. Will physicians who contract with third-party payors be paid less than the \$85?

A. Most third-party payors that contract with physicians have a clause in the physician agreement that states that contracting physicians agree to accept the fees established by the third party as payment in full. A third-party payor could establish a fee for screening mammograms at \$65 (or less). Physicians who sign these third-party payor agreements will not receive as much as they would have if the \$85 was the actual payment established by the payor.

Q. This new law applies to "screening mammography." Does the law define "screening mammography"?

A. Yes. Ohio law defines "screening mammography" as a "radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the X-ray examination of the breast using equipment that is dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, film and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast." The statute specifically states that the

term "screening mammography" does not include "diagnostic mammography."

Q. How should physicians bill for screening mammography? Should the physician charge his or her usual fee? What if the physician's usual fee for a screening mammogram is \$125?

A. The statute provides that the "benefit paid (for a screening mammogram) shall constitute full payment." This means that the physician is permitted and encouraged to charge his or her usual fee, in this example \$125. The physician is now required, however, to accept the benefit paid by the insurance company (an amount not to exceed \$85) as payment in full.

Q. What type of insurer must cover "screening mammography"?

A. House Bill 142 applies to all contracts for health-care benefits issued by health maintenance organizations (HMOs) and all health insurance policies issued by BCBS and other health insurance companies doing business in Ohio. The bill also applies to public employee benefit plans and certain employers. Medicaid coverage is required if approval for the use of federal funds is granted.

THIRD-PARTY UPDATE

my office, and if I didn't I might not have discovered that I was being shortchanged," he says. Travelers informed Dr. Williams that it had been using codes for a different area of the country when reimbursing Ohio physicians, and that that was the reason for the discrepancies.

When Edmond W. Gardner, MD, Columbus, questioned Railroad Medicare repeatedly about his reimbursement, they did not re-

spond. However, at one point the company did request he send a copy of the Ohio Medicare fee schedule to them. Dr. Gardner believes if he had not pursued the matter, no action would have been taken from Railroad Medicare. "They are responsible for Ohio and 14 other states. If they dinged each

physician even \$100, that could add up to millions of dollars they owe physicians - with interest," Dr. Gardner points out. Recently, Dr. Gardner began receiving his reimbursement checks in small amounts. "I'm just glad I got started before this got out of hand," he says.

If you feel that you are entitled to additional reimbursement from Railroad Medicare, you may want to contact Juliann Stires, The Travelers Insurance Co., Railroad Medicare, P.O. Box 10066, Augusta, GA 30999-0001 or call (404) 855-1386. ■

Insurers not due refunds for doctors' overcharges

Contrary to an article in the April 1993 issue of *Medical Community News*, a Community Mutual Insurance Company (CMIC) newsletter, Ohio physicians may not be required to refund an insurance company for overcharges. This overcharge provision was established under House Bill 478, Ohio's health-care reform legislation that was signed into law in January.

In its article CMIC stated that patients who notify their health insurers of overpayments by providers or hospitals can receive an incentive payment of 15% of the amount overcharged. The article went on to say that the provider will be required to refund the overpayment to the health insurer and will also be required to pay the patient the 15% incentive.

According to Deborah Bahnsen, OSMA staff counsel, the legislation does not mention any refund to insurance companies. However, she cautions physicians who are contacted about potential refunds to check their third-party payor contacts for refund provisions. What the legislation does stipulate is that hospitals, physicians and other health-care providers must pay a 15% reward to the patient and refund the overcharge on any bill for health-care services that exceeds the usual, customary and reasonable fee by more than \$500. Physicians who are approached about a potential refund should review their own records for accuracy and insist that their UCR be used as the basis to calculate any potential overcharge. ■

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- _____ Medicare Lab Fee Schedule
- _____ Medicare Newsletter Index

Physician's/Group Name: _____

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1500 Lake Shore Dr.
Columbus, Ohio 43204-3824

Ombudsman publications available

The following publications are available from the OSMA Department of Ombudsman Services, free of charge to OSMA physician members. Simply complete the order form at left or call the OSMA Department of Ombudsman Services at 1-(800) 766-6762, ext. 215.

DESK REFERENCE GUIDE

This guide, compiled by the Ombudsman staff, contains basic information, helpful hints, and general information to assist physicians and their office staffs dealing with Medicare, Medicaid, Workers' Compensation and private carriers. Also includes forms for ordering

CPT and ICD-9-CM code books and HCFA-1500 claim forms.

MEDICARE NEWSLETTER INDEX

Medicare has prepared an index of articles included in its physician newsletters from December 1988 through March 1993.

1993 MEDICARE LAB FEE SCHEDULE

Medicare's reimbursement for laboratory procedures was revised in April of 1993. This publication provides the updated statewide fee reimbursement levels for laboratory procedures. ■

Do you have questions about reimbursement?

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Flu shots covered by Medicare

Medicare has come to the conclusion that covering a minimal flu shot for the elderly may be cheaper than an expensive hospital stay. Consequently, as of May 1 flu vaccinations are now being covered by Medicare.

The Health Care Financing Administration (HCFA) predicts that a large number of Medicare beneficiaries will take advantage of the new coverage. Randy Hertzner, public information officer with the Ohio Department of Health, agrees. When HCFA conducted its flu vaccine demonstration in the Akron/Canton area from 1988-1992,

Hertzner reports the participation rate was very high.

"Providing the flu vaccination is not only a personal benefit to the elderly, but is also cost-effective. It

has been proven that \$1 worth of prevention saves at least \$10 down the road in medical costs," Hertzner says.

In Ohio, 2,400 deaths yearly are due to pneumonia and influenza, affecting mostly senior citizens. Whether the benefit will be cost-effective will depend on how many

individuals actually get the flu vaccine and the severity of the flu season, but the assumption from Hertzner and HCFA is that the new benefit will in the long run save not only lives but also money.

Physicians can expect to see Medicare claims billing instructions to cover flu vaccinations. ■

Ohio Flu Facts

15,000

- Average number of reported cases yearly

18,000

- Highest number of cases in a recent year

2,400

- Number of deaths due to pneumonia and influenza yearly

DEA increases registration fees

Physicians will see an increase in registration fees for their renewal applications with the Drug Enforcement Administration (DEA). Application fees have increased from \$60 to \$210 beginning with renewals after April 21, 1993.

The fee increase was passed by Congress as a part of public law 102-395 in October 1992.

The DEA's renewal form has not been updated to reflect the new fee, but the DEA is informing physicians about the change by including the following message on the application: **Your fee is not \$60. Your application fee is \$210.**

The AMA has filed a lawsuit regarding the fee increase.

Physicians who have questions about the new fee should contact the DEA at (202) 307-7255. ■



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Candid Shots

An Interview With OSMA President Walter A. Reiling, Jr., MD

This may be the stormiest year yet at medicine's helm, as health-care reform, at both the national and state level, threatens to rock the profession. Here, OSMA's new president talks candidly about the year ahead – and his plans to keep medicine on course.

Q. Obviously the issue of health-care reform will be the dominant issue this year and next, at both the national and state level. What types of problems do you think health reform will create for medicine?

A. Health reform is the number one item on OSMA's agenda this year, and on my personal agenda as well.

One of the biggest problems I see coming out of the reform issue is the way that it is fragmenting medicine – and I'm cynical enough to believe this "divide and conquer" strategy is politically motivated.

Medicine needs to find a common ground, right now, and build on that. We need unity. We also need to position the OSMA so that it can respond to the issues raised by health reform as soon as possible.

Q. The OSMA's Health-Care Reform Task Force, which you chair, is one way that the OSMA is taking the initiative on health reform. But isn't it true that some of your final recommendations won't be popular with members?

A. I assume, and the task force also assumes, that in an attempt to achieve a consensus on health reform, no one will be totally happy with the whole package. There are issues of cost-containment, for example, that must be addressed, and it's true that our solutions probably won't be endorsed by all physicians. There is a great deal of diversity on the task force on funding issues. We have had everything proposed, from a switch to a Canadian-style health-care system to a more conservative, 1930s approach. Yet this group can still work well together. Its members are informed and enlightened, and their interests are directed to the patient. I've not seen any examples of self-interest that some critics suggest.

Q. Membership has been an interest of yours for a number of years, but is membership in the OSMA becoming a harder "sell" these days?

A. Unfortunately, I think it is. Physicians are feeling a financial squeeze these days, and they're asking pertinent questions about the expenditure we ask them to make. We have to justify the cost, and I think we can, but it's an issue we will have to address more and more.

I don't think we need to change what we're doing, but we do



need to convey more frequently the benefits of OSMA membership. This can be difficult to do. For example, I think one of the most effective things we do is legislative lobbying, but it's not easy to brag about our accomplishments, like those items we were able to have removed from House Bill 478, when physicians are focused on the unpleasant things that stayed in the bill.

Q. What goals have you set for yourself this year?

A. First, to complete the work on the task force, and produce a credible product that we can take to the Legislature. Second, to clear up the PICO issue completely. Third, to take steps to solidify the membership, and to increase it. I also want to try to form a stronger alliance with the specialty societies, as I believe that will promote a stronger voice for medicine. Finally, I want to try to maintain as much of my practice volume as I can. I want to be a president who is, at the same time, a practicing physician.

Q. What's the one scenario you hope you don't have to contend with this year?

A. I'm afraid that if the Clinton reform proposal is delayed, or becomes deadlocked in Congress, that the state Legislature will take the matter of health-care reform into their own hands. If that happens, then I think we run the risk of seeing some ill-conceived endeavors coming out of that group, and we'll have to live with them. It's also possible that the OSMA will lose membership as a result of those actions.

Q. The role of OSMA president is an arduous, time-consuming job. Why take it on? What do you personally gain from it?

A. The satisfaction of having been involved – of being part of the solution. I have been concerned with the direction that medicine has been heading, but realized that if I wanted to criticize, I needed to become involved in the process.

Fortunately, I have three partners who are very supportive, and that enables me to take on this position, and become involved. Ultimately, however, I want medicine to continue to be a desirable profession and I hope that, by expressing my views, I can help toward that end.



Third-party restrictions put physicians on the spot

Legal hot water may be brewing for physicians who don't realize that they are ultimately accountable for their patients' care – regardless of third-party restrictions.

Often, third-party payors such as Medicare, PPOs and HMOs restrict referrals, the kind and number of tests a physician may order, and the length of hospital stays.

As a physician with the best interest of the patient in mind, do you ignore the restrictions or adjust your treatment plan? Worse, if you accept the third party's decision and a bad outcome occurs, who is responsible – the physician or the third party?

Unfortunately, in most cases juries are unsympathetic toward physicians who "skimp" on patient care, regardless of the reason. And while there's no way physicians can protect themselves completely from patient backlash, (i.e. a lawsuit), there are ways of diffusing

the situation when a third party attempts to restrict your practice of medicine:

1. Practice good, sound medicine. If a third-party payor refuses to reimburse for a certain test or

plain why a certain treatment is necessary.

2. Be a patient advocate. Tell your patient that they are your first concern. You should avoid blaming the bureaucracy of the third party,

your treatment plan, making sure that the patient understands he or she will be responsible for payment of the procedure if reimbursement is denied.

3. Document the patient's response. If the patient waives the treatment because of cost, make sure you document that the risks of such action were explained to the patient.

4. Termination of care. Though a last option, there may be times when you feel you can no longer accept the third party's restrictions and still practice good, sound medicine. In that case, you may consider ending the physician/patient relationship by giving the patient written notification (giving at least two weeks notice), explaining the reason for the termination, and referring them to another qualified physician in the area. ■

If a third-party's restriction results in a bad outcome, in most cases the physician will be held responsible.

treatment, review the reason you wanted to order it – is it critical for a diagnosis or is it for confirmation? If you think the treatment is critical to the patient's care, make every effort to change the third party's decision and *document everything*. Also, keep the patient apprised of your efforts and ex-

but you should make your patient aware of the controversy. When possible, write a letter to the third party explaining the reason for your treatment plan, the possible outcome if it is not followed, and forward a copy of it to your patient. Meanwhile, you should encourage the patient to accept

Doctors may put peer review boards on trial

A rash of antitrust lawsuits, brought against hospital peer review committees by physicians, has some questioning the feasibility of the profession to police itself.

For years, hospital peer review committees – made up of physician colleagues – have been employed as a way of cracking down on incompetent physicians and warding off unnecessary malpractice lawsuits. But physicians, wary that a single bad review can threaten their careers, are increasingly filing antitrust lawsuits against hospital committees.

REVIEWERS NOT IMMUNE

After passage of the Health Care Quality Improvement Act of 1986 (HCQIA), many physicians involved in peer review activities believed that the act provided immunity from being sued.

However, the immunity granted under the HCQIA is immunity from damages, not immunity from suit. This means that physician members of a review committee, as well as the entity that organizes the review committee, can be named in

a lawsuit and may have to defend the lawsuit, at least in the preliminary stages. Yet, if the committee and its members follow the fairness standards and reporting require-

One attorney says that a bad review by a board amounts to what he calls "a pretty effective blacklist."

ments outlined in the HCQIA, they will not be liable for damages alleged in a lawsuit for the actions taken as a part of the review process.

Two recent federal appeals court rulings – including one in Ohio – support this position. The courts have said that hospitals and committee members are given limited immunity from being forced to pay monetary damages under the 1986

law. However, they ruled, if a physician has a legitimate complaint about how his or her peer review was conducted, the physician may file suit, gather evidence and proceed with litigation.

Physicians who prove that a committee unfairly reviewed them may sue to have their privileges reinstated and their data bank records cleared.

OHIO PHYSICIAN FILES SUIT

Take the case of Lima Memorial Hospital, whose peer review committee last year revoked a physician's X-ray reading privileges. The physician filed suit, claiming that the review board acted, not out of concern for the safety of patients, but because the physician was planning to open a rival laboratory service. A three-judge appellate panel ruled the case had legitimacy and that it should continue with pretrial fact-gathering.

A lawyer for the hospital says, however, that a committee's motive is irrelevant as long as it gives the physician a fair hearing. Further, she says, such a litigious environ-

ment will not only make malpractice costs soar, but it will discourage physicians from serving on review committees, which are necessary for improving patient care.

AN "EFFECTIVE BLACKLIST"

What the courts will have to consider in the future (the attorneys for Lima Memorial expect to ask the U.S. Supreme Court to resolve its dispute) is congressional intent:

The hospitals contend that the act of 1986 grants their peer review boards protection from court challenges. But physicians argue that the law wasn't meant to bar all challenges of peer review decisions. Without the privilege of retribution, they say, physicians are at the mercy of review boards who may purposely or maliciously make unfavorable reports.

And those bad reports are sent to the practitioner data bank, which is tapped by hospitals and institutions across the country, something one attorney says is the equivalent of "a pretty effective blacklist." ■

Ban on balance billing challenged

The Ohio Physicians Defense Foundation continues to pursue its suit against the ban on balance billing Medicare patients, contained in House Bill 478, which passed the Ohio Legislature last year.

The foundation has retained Medicare litigation expert Kent Masterson Brown to serve as its attorney. Brown successfully argued in New Jersey courts that Medicare patients had the right to contract independently, on a case-

by-case basis, outside of Medicare without risking their status in the Medicare program (*Stewart v. Sullivan*). More recently, he forced the administration's Health-Care Task Force, chaired by First Lady

Hillary Rodham Clinton, to open its meetings to the public.

At its Annual Meeting this past May, the OSMA House of Delegates voted to provide "encouragement and moral support" to those who have chosen to test the constitutionality of the mandatory assignment provision. ■

Guide to Ohio Law

The OSMA Legal Department is currently working on updating the *Physician's Guide to Ohio Law*.

Watch *OHIO Medicine* for more information on how to order the manual.

Update

Parental notification

For the second time, the state's parental notification law, which requires girls under 18 to obtain approval from a parent, guardian or judge before obtaining an abortion, is being challenged in federal court. Presently, a provision in the law allows a girl to bypass a parent and seek a judge's permission to have an abortion. However, she must prove she is mature enough to make that decision herself. Plaintiffs state that the law fails to list specific guidelines for judges to determine a girl's maturity. The matter is presently under review by a three-judge panel of the U.S. Court of Appeals. No ruling date has been set.

Doctor sues hospital

A Sidney, Ohio internist, Florencio Reyes, MD, has filed a federal lawsuit charging Wilson Memorial Hospital with terminating his privileges because he refused to order expensive tests on elderly patients. Dr. Reyes' suit states that he is reluctant to take heroic measures on elderly patients because he considers such procedures to be unethical and inhumane, despite the fact that they generate substantial income for the hospital.

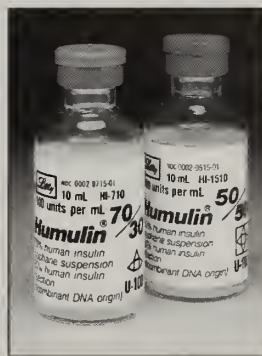
The lawsuit asks the federal court to issue an order prohibiting the hospital from terminating Dr. Reyes' contract, and for \$2.5 million in actual damages and at least \$2 million in punitive damages.




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Legal Notes

In Brief: This column is condensed from the OSMA's legal fact sheet notebook. You may want to cut and save this column for reference. Questions should be referred to the OSMA's Department of Legal Services.

Employment Law – Required Postings

This article is for general informational purposes only. It is not meant to be a comprehensive guide regarding the required employment law postings. Each agency listed will provide copies of required posters, which must be posted in a conspicuous place. Specific questions should be directed to the agency.

1. U.S. Department of Labor – Federal Wage and Hour Division – (614) 469-5677

- Notices relating to minimum wage provisions, maximum wage and exemptions
- Employee Polygraph Protection Act of 1988

• Family and Medical Leave Act of 1983

2. Ohio Department of Industrial Relations – (614) 644-2239

- Ohio Minimum Fair Wage Standards

3. Occupational Safety and Health Administration (OSHA) – (614) 469-5582

- Job Safety and Health Protection Act (Poster #2203)
- Occupational Safety and Health Act of 1970

4. Equal Employment Opportunity Commission (EEOC) – 1-(800) 669-3362

• Consolidated EEOC Poster (EEOC-P/E-1)

• Civil Rights Act of 1964

• Age Discrimination in Employment Act of 1967

• Americans With Disabilities Act of 1990

5. Ohio Civil Rights Commission (OCRC) – (614) 466-2785

• Ohio Fair Employment Practice Law Poster

6. Ohio Bureau of Workers' Compensation – (614) 466-6600

• Workers' Compensation

False names on prescriptions investigated

It has come to the attention of the OSMA that some physicians are writing prescriptions for drugs used in the treatment of AIDS under a false name for the patient. It is understandable that an AIDS patient is concerned with protecting his or her identity, however the practice of prescribing drugs under a false name is illegal. Ohio Revised Code Section 2925.23 states that "no person shall knowingly make a false statement in any prescription, order, report or record..." and that "no person shall intentionally make, utter or sell or knowingly possess a false or forged prescription."

The pharmacy board has investigated two cases involving false prescriptions of this nature, which have been referred to prosecutors. No prosecutions have been made at this time, however that is not to say that this offense will not be vigorously pursued. This offense is a fourth-degree felony and may result in a jail term of six months to five years and/or a fine of no more than \$2,500. This is for the first offense only.

According to Ohio Administrative Code 4729-5-17 (G), prescriptions are not public records and persons having custody of or access to prescription records may not divulge any information regarding a prescription to anyone except the patient receiving or the physician prescribing the drug, a licensed health-care person responsible for the patient's care, a member, inspector or investigator of the Board of Pharmacy who is engaged in a specific investigation involving the drug or a specific person, or an agency responsible for providing medical care for the patient upon written request.

If presented with a request for a prescription under a false name, by an AIDS patient or any patient you are treating, please advise them that such practices are illegal and that their prescription records are protected from disclosure under Ohio law. They should also be informed that there are criminal and civil remedies available for unauthorized disclosure of such information. ■

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Ohio smoking bans more restrictive than ever

Is Ohio becoming more smoke-free? Moves made across the state in recent years seem to indicate that the air is clearing considerably. For example:

Akron – Has banned smoking in all city-owned buildings and companies with 25 or more employees must provide a smoke-free environment.

Cincinnati – A 1985 resolution

outlaws smoking in public places and mandates that certain places, such as restaurants, separate smokers and non-smokers. Only bars and bowling alleys are exempt.

Cleveland – A 1987 ordinance bans smoking in several public buildings, but allows designated smoking areas in most buildings. Bars are exempt.

Dayton – Prohibits smoking in city-owned buildings, except for employees' offices, restrooms and vehicles with one occupant.

Toledo – A Clean Indoor Air Act, passed in 1987, bans smoking in most public areas, but allows restaurants, hotels and motels and public and city-owned buildings to designate smoking areas. Bars and restaurants seating fewer than 40 people are exempt.

Youngstown – A smoking policy is now being prepared for consideration by City Council.

Now, Franklin County is considering what is likely to be the most restrictive smoking policy in the state. The Columbus and Franklin County boards of health are considering a proposal that would ban smoking in nearly all



public places, including bars, restaurants, bowling alleys and shopping malls. Three public hearings on the matter have been held, and written testimony on both sides of the issue has been accepted. Action on the proposal is expected to be taken by the end of the summer. ■

Help Your Patients to Stop Smoking

"How to help your patients stop smoking," a National Cancer Institute manual for physicians, is a booklet to help physicians use the limited time available with patients to promote smoking cessation. The publication includes a reproducible "smoking assessment" form and a card-sized "quit smoking" contract. NCI suggests that physicians "ask, advise, assist and arrange."

Copies of this publication are available from the Ohio Tobacco Risk Reduction Program, Bureau of Chronic Diseases, Ohio Department of Health, PO Box 118, Columbus, OH 43266-0118, (614) 466-2144.

Revised Answers to Questions About the SRF Refund

Q. Who is eligible for a refund?

A. You are eligible for an SRF refund only if you practiced in Ohio and carried medical liability insurance coverage during the years 1975-1980. Approximately 16,000 physicians' groups and hospitals may qualify. Approximately \$20 million, minus administrative expenses will be distributed to claimants.

Q. Will I be notified if I may be eligible to apply for a refund?

A. You should be. The SRF, with the assistance of the OSMA and other professional groups, has made every effort to notify eligible physicians by mail. In addition, to catch the attention of those it might have missed, the SRF has placed notices in local papers and publications such as *OHIO Medicine*. However, it is always possible that you may be eligible for a refund and still not have received a notice. If that is the case, please write the SRF board

for an application form.

Q. How much money will be returned to me?

A. It depends upon how much you contributed into the fund, for how long and how much money was returned to you in 1980. The final refund for any one physician will not be determined until after the expiration of the period for filing claims – November 12, 1993. Any request for information concerning the specific amount of your refund cannot be answered by the SRF at this time.

Q. I remember that some SRF money was returned to me in 1981. Will that affect the amount of this current refund?

A. Again through the efforts of the OSMA, a portion of the SRF funds were returned to policyholders in 1980, and, yes, that will affect the amount you receive.

Q. How do I claim my refund?

A. You *must* complete a proof-of-claim form that is being distributed by the SRF and return the form to the SRF by no later than November 12, 1993. You also must complete a W-9 tax form that accompanies the claim form. You will not receive a refund unless you submit a claim. Claim forms may be obtained from: The Stabilization Reserve Fund, P.O. Box 267112, Columbus, OH 43226-7112, (614) 888-8901.

Q. What happens to the refund if the physician eligible to receive the money is deceased?

A. This is a very complex issue, and the answer depends upon the individual's specific situation. Persons in this situation need to consult the SRF.

Q. What happens if a corporation (for example, a hospital) paid the premiums for one or more physicians? Will the corporation receive an SRF notification letter?

A. No. The notification letter was sent to those parties named as policyholders, not to those who paid the bills. Likewise, refunds will be mailed to policyholders, not the entity that paid the bill. If the corporation believes it should receive the refund, it will have to collect it from the policyholders.

Q. When will I receive the refund?

A. At this time, the JUA hopes to have the SRF checks in the mail by the end of 1993.

Q. Do I have to declare my refund on my 1993 tax return?

A. The SRF will report refunds to the Internal Revenue Service on a 1099. The treatment of your refund will have to be determined on an individual basis by your tax consultant.

Q. Where may I get further information?

A. Call the SRF at (614) 888-8901.

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CLEVELAND, WEST SIDE - Internal medicine group has office space to share. Ideal situation for the physician wishing to decrease office cost and managerial responsibility. Write to Box 252, c/o OHIO Medicine, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

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positions available in Wisconsin, Ohio and Michigan. We would be happy to provide you with further information. Please call 1-(800) 243-4353 or send your C.V. to **STRELCHECK & ASSOCIATES, INC.**; 10624 N. Port Washington Road, Mequon, WI 53092.

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border; internal medicine positions in Wisconsin; OB/GYN positions in southeastern Wisconsin. We would be happy to provide you with further information. Please call toll-free, 1-(800) 243-4353 or send your C.V. to **STRELCHECK & ASSOCIATES, INC.**; 10624 N. Port Washington Road, Mequon, WI 53092.

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OBITUARIES

HERBERT E. BILL, MD, Cleveland; Case Western Reserve University School of Medicine, 1936; age 84; died April 15, 1993; member OSMA and AMA.

GILBERT ERLECHMAN, MD, Ft. Lauderdale, FL; Ohio State University College of Medicine, 1960; age 58; died April 13, 1993; member OSMA and AMA.

PAUL S. FANCHER, MD, Columbus; Ohio State University College of Medicine, 1930; age 89; died April 1, 1993; member OSMA and AMA.

JOHN P. GARVIN, MD, Columbus; University of Cincinnati College of Medicine, 1944; age 73; died May 7, 1993; member OSMA and AMA.

WALTER KATZENMEYER, MD, Cleveland; Case Western Reserve University School of Medicine, 1941; age 78; died April 22, 1993; member OSMA and AMA.

KAZEM KHOIL, MD, Xenia; Faculty of Medicine, University of Teheran, Teheran, Iran, 1963; age 55; died March 24, 1993; member OSMA.

ELIZABETH Y. KUFFNER, MD,

St. Marys; George Washington University School of Medicine, Washington, DC, 1937; age 87; died March 19, 1993; member OSMA and AMA.

FRED M. LAMPRICH, MD, Youngstown; Medizinische Fakultät der Universität Heidelberg, Heidelberg, Baden-Württemberg, Germany, 1939; age 81; died April 10, 1993; member OSMA and AMA.

GERONIMO LUSTRE, MD, Dover; Faculty of Medicine and Surgery University of Santo Tomas, Manila, Philippines, 1955; age 63; died March 29, 1993; member OSMA and AMA.

JOSEPH A. McCARTHY, MD, Toledo; Loyola University Stritch School of Medicine, Maywood, IL, 1954; age 63; died March 16, 1993; member OSMA and AMA.

ROBERT V. MCMAHON, MD, Cleveland; New York Medical College, New York, NY, 1953; age 69; died April 10, 1993; member OSMA and AMA.

ROBERT H. MOONEY, MD, Barefoot Bay, FL; St. Louis University School of Medicine, St. Louis, MO, 1938; age 81; died April

25, 1993; member OSMA and AMA.

CHRISTOPHER PALANS, MD, Toledo; University of Vermont College of Medicine, Burlington, VT, 1944; age 75; died March 30, 1993; member OSMA and AMA.

WILLIAM SETTLE, MD, Toledo; University of Minnesota Medical School, Minneapolis, MN, 1988; age 31; died March 15, 1993; member OSMA and AMA.

EDWARD W. SHANNON, MD, Willoughby; Case Western Reserve University School of Medicine, 1941; age 79; died April 12, 1993; member OSMA and AMA.

JAMES M. SMITH, MD, Hamilton; Pritzker School of Medicine of the University of Chicago, Chicago, IL, 1949; age 67; died April 12, 1993; member OSMA and AMA.

MARSHALL R. WERNER, MD, Akron; St. Louis University School of Medicine, St. Louis, MO, 1933; age 85; died May 8, 1993; member OSMA and AMA.

ASIA H. WHITACRE, MD, Chesterhill; Ohio State University College of Medicine, 1929; age 94; died April 4, 1993; member OSMA

and AMA.

PHILIP J. WOODWORTH, MD, The Plains; University of Cincinnati College of Medicine, 1936; age 84; died April 23, 1993; member OSMA and AMA. ■



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OHIO *Medicine*

News for Members of the Ohio State Medical Association

Photo by Jack Kustron

Court rules on doctor/patient sex

In Brief: The Ohio Supreme Court ruled in *Pons v. State Medical Board* that the board was within its statutory code of authority when it disciplined an OB-Gyn for having consensual sex with a patient.

The Ohio State Medical Board can discipline a physician for having consensual sexual relations with a patient, based on charges of violations of minimal standards of care and ethical prohibitions. That was the decision recently handed down by the Ohio Supreme Court in the case of *Pons v. State Medical Board*.

Pablo A. Pons, MD, of Oregon, Ohio, an obstetrician/gynecologist, had a consensual sexual relationship with a patient from 1976 until 1983. The medical board brought disciplinary charges against Dr. Pons in 1989, claiming there was failure on his part to maintain minimal standards of care, even though there was no evidence that showed medical care rendered the patient was lacking. In 1990, the

See **SEX** page 2



Women's Health

Gov. George Voinovich thanks OSMA's President-Elect Claire V. Wolfe, MD, for the association's support of S.B. 131, which creates the office of women's health initiatives within the Ohio Department of Health.

Delivery rates evened

In Brief: Community Mutual Insurance Company increased the rate for vaginal deliveries, while the rate for caesarean sections stayed the same, essentially creating one fee for deliveries.

Recent news reports that Community Mutual Insurance Company, one of the region's largest health insurers, has reduced payment for

caesarean section deliveries are inaccurate, says Joseph Berman, MD, CMIC vice-president of Clinical Affairs.

"On July 1, CMIC began to convert to an RBRVS system of payment," he says. "Under the realignment, the weighting for caesarean section deliveries and vaginal deliveries were about the same. We increased the rate for vaginal de-

See **DELIVERY** page 2

Statewide Medicare fee schedule

Doctors urged to write HCFA

In Brief: HCFA says it will convert Ohio to a statewide Medicare fee schedule if it receives enough letters of support from Ohio physicians by September 13.

Now HCFA says it wants letters.

In the latest chapter of the OSMA's continuing campaign to convince the Health Care Financing Administration (HCFA) to convert to a single statewide Medicare fee schedule, the OSMA has learned that HCFA is soliciting physician comment regarding the proposed change. If HCFA receives what it considers to be enough letters of support from Ohio physicians, it will convert the state to a statewide fee schedule effective

January 1, 1994.

Ohio physicians are urged to write HCFA regarding their position on the proposed conversion to a statewide fee schedule. All correspondence must be received by HCFA no later than 5 p.m. Monday, September 13. Correspondence should be addressed to: HCFA, Attention: BPD-770-P, P.O. Box 26688, Baltimore, MD 21207 (HCFA has requested that physicians send a letter plus three copies).

Currently Ohio has 15 pricing regions for Medicare, based loosely on cost-of-living

See **FEES** page 2

Inside

TOP LEGISLATIVE BILLS: Physician license fees increase and nurses' scope of practice expands after the Legislature approved two bills before its summer recess. **3**

HEALTH-CARE COMMITTEES: The Ohio Health-Care Board's committees and subcommittees are working all summer on ways to revise the state's health-care system. **6**

ACADEME: Academic physicians say organized medicine needs to take a look at their unique problems. **15**

PRESCRIPTION GUIDE-LINES: A medical board member tells what physicians need to know when prescribing drugs for their patients. **18**



Pattye Whisman, MD

MANAGED CARE: Dr. Pattye Whisman talks about the Licking Memorial Hospital Health Plan, which is gaining national attention. **25**

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differences between urban and rural areas. The OSMA is in favor of converting to a single statewide fee schedule as the result of a resolution adopted at its 1992 OSMA Annual Meeting. When the OSMA notified HCFA of its position, HCFA indicated that it needed more proof of physician support before making the change. Specifically, HCFA wanted assurance of support from the physicians in the 15 counties that stood to receive lower reimbursement as the result of a conversion to a statewide schedule.

Of the 15 medical societies OSMA contacted last summer, 11 indicated support of the statewide Medicare fee schedule, two expressed opposition and two did not respond. OSMA's letter to HCFA in January

of this year reporting these results has gone unanswered despite repeated contacts.

The OSMA learned of HCFA's request for letters from Ohio physicians by reading the July 14, 1993

"...now this issue is in the hands of our members."

Federal Register. HCFA indicates in the Federal Register that a total of six states have submitted formal petitions that "contained information concerning the level of support for the change among physicians in

both winning and losing areas. "Of the six, only Ohio and North Carolina have "demonstrated sufficient support from losing areas to support the change."

WISCONSIN REQUEST REJECTED

The OSMA just recently learned that HCFA had rejected a request from the State Medical Society of Wisconsin for a single statewide fee schedule. However, in Wisconsin there is significantly less support for a statewide fee schedule among "losing" physicians than there is in Ohio.

In Ohio, the two county societies that have expressed opposition to the conversion represent 1,905 active member physicians, or only 35.5% of the losing physician members of OSMA.

In Wisconsin, 70% of losing physicians oppose the change.

OSMA ASKS DOCS TO WRITE

William Fry, director of the OSMA's Department of Ombudsman Services, is urging Ohio physicians to write HCFA immediately. "The letters need not be lengthy, but HCFA does need to hear directly from Ohio physicians regarding this issue. The OSMA has done everything possible to follow the mandate of the OSMA House of Delegates to support a statewide fee schedule, but now this issue is in the hands of our members."

The OSMA will be contacting county medical societies directly regarding this issue and will send a letter to the HCFA restating the association's position. ■

SEX...From page 1

board suspended Dr. Pons' license to practice medicine and surgery indefinitely. Dr. Pons appealed the ruling, but it was upheld by the Franklin County Common Pleas Court.

However, a year later, in 1991, the Franklin County Court of

minimal standards of care could be used to measure overall care.

ETHICAL ARGUMENTS

The court also found that the medical board was well within its statutory authority to determine

BROAD AUTHORITY

Ultimately, the Supreme Court's decision establishes the ability of the medical board to broadly define "minimal standards of care" to encompass any portion of the physician-patient relationship and reaffirms the board's ability to act as its own expert on technical medical issues.

"I don't believe that the volume of cases will increase in the future as a result of the court's decision," says Katrina English, JD, director of OSMA's Legal Department. "However, the board now has more latitude in disciplining physicians who fail to meet minimum standards, and since, in this case, 'minimum standards' has been so broadly defined by the court, we may see the board more actively charging physicians with failure to meet minimum standards of care."

She adds that, because of the Pons decision, the medical board may also be more willing to discipline doctors on ethical issues than they have in the past.

AFFECT ON HB 102

As far as how the court's decision will affect the outcome of House Bill 102, a bill that prohibits doctor-patient sex, John Van Doorn, director of OSMA's Department of Legislation, says it virtually eliminates the need for the bill.

"The court's decision has given the board the same powers outlined in the bill so we will advocate that the Pons decision dismisses the need for HB 102," he says.

The OSMA has already gone on record as opposing the legislation, saying that physicians' ethical guidelines makes the bill unnecessary. ■

Because "minimum standards" has been so broadly defined, we may see the board more actively charging physicians with failing to meet them.

Appeals overruled the Common Pleas Court decision, saying that the medical board could not discipline Dr. Pons without proving the sexual relationship resulted in improper medical care. In 1992, the Ohio Supreme Court declined to hear the case, but changed its mind this past June.

AMICUS BRIEFS FILED

In amicus briefs filed with the high court, both the OSMA and the AMA argued that the term "standard of care" relates to negligence, and is a standard used to measure the activity of a professional. OSMA argued that, because the medical care rendered was adequate, it was unfair to discipline Dr. Pons on the charge of failure to maintain minimum standards of care.

The Supreme Court, however, sided with the board, arguing that

that Dr. Pons violated the AMA Code of Ethics.

Neither the OSMA nor the AMA condone physician-patient sexual relationships, however at the time of Dr. Pons' consensual sexual relationship with his patient, AMA ethical guidelines were less clear on this issue than they are at present, so the OSMA argued that Dr. Pons could not have anticipated that charges would be brought against him if the medical care he rendered did not fall below minimal standards.

The court, however, reaffirmed previous case law stating that the board is capable of determining when conduct falls below minimal standards of care – determining that a sexual relationship with a patient is a violation of minimal standards, even if the actual medical care rendered is adequate.

DELIVERY...From page 1

liveries, and that equalized the reimbursement, but physicians who file claims for c-section deliveries now will be receiving the same payments they received on June 30. They'll receive more for vaginal births, which makes the payment for both procedures the same."

Dr. Berman declined to tell, for publication, how much the vaginal delivery rate was increased, however he says it's not secret and CMIC would relate that information to any physician who wishes to call.

CONCERN OVER C-SECTION RATE

That doesn't mean, however, that the insurance company is not concerned about high caesarean delivery rates for the state. Dr. Berman says he is convinced that c-section rates in Ohio are too high.

Ohio Department of Health statistics place the c-section rate at 23.6%, just slightly higher than the national rate of 23.5%. CMIC wants to see that rate cut to 20% in Ohio, and the U.S. Public Health Service wants to see the

Continued next page

State budget, Medicaid bills expected to affect physicians

The Ohio Legislature recessed on July 1, and since legislators are not expected to reconvene until fall, now is a good time to examine those bills that were dealt with in the final weeks of the session. Here is a brief look at the top two bills that affect Ohio physicians.

1.) STATE BUDGET

- Medical license fee to increase
- Director of Health no longer required to be a physician
- Medicaid reimbursement for physician services increased

The Ohio Legislature passed a \$30.8 billion, two-year state budget that contains numerous issues within its 2,400+ pages. After vetoing 31 items, Gov. George Voinovich signed the bill. However, he did not veto the item that OSMA urged him to ax – the repeal of the law that requires the director of the Ohio Department of Health to be a physician.

Other items of interest:

- Increases the physician licensure fee from \$160 every two years to \$250 with \$20 of that sum dedicated to funding a primary care physician loan repayment program that will provide grants to primary care physicians who contract to practice in underserved Ohio areas.
- Raises Medicaid reimburse-

ment for physicians who provide primary care services to 75% of the average Medicare rates for such services.

- Allows the creation of managed care programs for Medicaid recipients in Franklin, Hamilton and Lucas counties.
- Creates a Medicaid demonstration project in Butler County.
- Allows the University of Cincinnati to establish a nurse demonstration project.
- Funds the Ohio Cancer Incidence Surveillance System at \$250,000 per year.

In an unexpected move, House Bill 28 was included in the final version of the state budget bill. The OSMA and other provider groups had advocated inclusion of more protections, such as a due process clause, but those were not incorporated.

2.) MEDICAID REFORM BILL

- Nurse practitioners' and physicians assistants' practices expanded.
- Establishes a Medicaid demonstration project for Butler County.

House Bill 183, sponsored by Rep. Paul Jones (D-Ravenna), was passed by the Ohio House. It would permit PAs to:

Summer Legislative Report

- Be employed by institutions.
- Prescribe Schedule IV and V drugs, under physician supervision but only in health manpower shortage areas.
- Increases the authority of the PA Regulatory Committee.

Nurse practitioners would be permitted to prescribe Schedule III, IV and V drugs under physician supervision but only in health manpower shortage areas.

The Butler County project will:

- Be governed by a special board, of which physicians will constitute a majority.
- Require the start of a managed care system for Medicaid patients in the county.
- Require that guidelines be set to show physicians and other providers how many Medicaid patients they should voluntarily treat in a year.
- Permit the board to define how nurse-practitioners and PAs might prescribe drugs and perform primary care services under physician supervision. ■

(See related stories on page 5.)

Legislators pass Workers' Comp bill

At press time, legislators had just passed House Bill 107, a reform and budget package for the Workers' Compensation system.

"The bill achieves Gov. Voinovich's goals of introducing managed care into the state's Workers' Comp system," says John Van Doorn, director of OSMA's Department of Legislation.

The OSMA worked with other health-care provider groups and labor to assure that patients would continue to enjoy the freedom to choose their own doctor. In a last-minute skirmish with the business

community, says Van Doorn, that wording was defeated.

However, the OSMA was successful in giving physicians a voice on a new BWC committee that will recommend guidelines for managed care entities to the BWC board.

"The OSMA also sustained physicians' ability to appeal to a legislative body any rules that are promulgated by the BWC board," says Van Doorn.

Next month, *OHIO Medicine* will present an analysis of this bill and what it will mean to physicians. ■

c-section delivery rate go down to 15% nationally.

ACOG'S VIEW

No one knows that better than Lance Talmage, MD, a Toledo OB-GYN and the chair of the Ohio Chapter of the American College of Obstetricians and Gynecologists (ACOG), as well as head of OSMA's Hospital Medical Staff Section. He says ACOG has been concerned with the rate of caesarean deliveries for several years.

"Our group has advocated a closer quality assurance system to review why caesarean section deliveries were done, and we've

encouraged VBACS – vaginal births after caesareans – as a viable option for patients, as long as they're informed about the risks and aren't excluded for medical reasons," he says.

He doubts, however, that any move insurers make to eliminate or decrease compensation for c-sections will decrease the number that are done.

FEE NOT MOTIVATOR

"There is an erroneous belief among some insurers that, because of the rate paid for caesarean deliveries, there is an incentive to do more of them," he says. "But most

reputable doctors don't base their decision to do a c-section on finances. In some cases, it's actually worth more to do a vaginal delivery."

CMIC's Dr. Berman agrees: "I've never believed the c-section rate was driven by costs." Yet he says he's often stumped by customers who want to know why the c-section delivery rate is what it is.

"Dr. Talmage, on his own, has offered to help us address our concern with Ohio's high caesarean delivery rate," Dr. Berman says. "However, I want to re-emphasize that the realignment and equalizing of fees for vaginal

and caesarean deliveries had to do with the change to an RBRVS system, and should not be construed as a method we're using to lower the c-section delivery rate."

Dr. Talmage says some physicians may consider CMIC's move objectionable, as another method of insurers to reduce compensation for a higher-risk procedure that involves more time, technical skills and medical-legal risks.

"Vaginal births can be just as risky, though," says Dr. Talmage who adds that, from a personal viewpoint, he sees no problem with a single fee for deliveries. ■

Bill to drop patient/physician confidentiality in DUI cases

If Senate Bill 121 passes the House, physician-patient confidentiality won't apply to the tests, or the results of any test, that determines the concentration of alcohol or

drugs in the body. This would apply in criminal cases only.

The bill, sponsored by Sen. Betty Montgomery (R-Perrysburg), was introduced after questions were

raised about the invasiveness of the tests, and whether or not a physician should testify about what the tests reveal.

In a news release from his office,

Sen. Richard H. Finan (R-Cincinnati) said that without such language, it's difficult to find anyone to conduct the tests, and without the tests, many DUI cases are lost in court.

The bill passed the Senate before the Ohio Legislature recessed for the summer. The House will consider the bill in the fall. ■

Law provides coverage for kids' preventive care

Ohio physicians will now need to work with insurance companies when they provide preventive health care for children up to the age of nine.

A provision in House Bill 478, the health-care reform measure

Coverage is capped at \$500 from birth up to age one.

that passed the Ohio Legislature last year, became effective July 1. The provision requires insurers to cover preventive health care for children up to the age of nine.

Lawmakers sought to increase the level of health care to children by mandating that every health insurance policy that covers the insured's family must now include "child health supervision services." Those services are defined by the new law as "periodic reviews of child's physical and emotional status by a doctor or by a health-care professional under supervision by a doctor," and may include medical history, complete physical examination, developmental assessment, immunizations and laboratory tests.

Coverage is capped at \$500 for children from birth up to the age of one. A total of \$150 is allowed for such services each year after the first, up to the age of nine. ■

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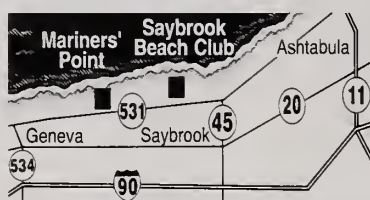
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Flurry of bills considered before Legislature recesses

The Ohio Legislature considered the following bills before recessing for the summer:

House Bill 215 Mammography

- **What it does:** Would require physicians to provide a written report on a patient's mammography results if the patient requests that report. It would also require physicians to inform their patients of their right to receive this report.
- **OSMA position:** The OSMA and the Ohio Radiological Society oppose this bill.
- **Action taken:** Passed Ohio House, now goes to the Senate for consideration.

House Bill 314 Managed Competition

- **What it does:** Would establish a regionalized managed competition system in Ohio, similar to that thought to be supported by the Clinton administration.
- **OSMA position:** No position
- **Action taken:** Remains in the House health committee.

House Bill 102 Sexual Contact With Patients

- **What it does:** Would allow

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disciplinary action against any physician who engages in sexual contact with a patient.

- **OSMA position:** OSMA opposes this legislation as unnecessary
- **Action taken:** Referred to a subcommittee of the House Civil and Commercial Law Committee.

House Bill 355 Recognizing Child Abuse

- **What it does:** Physicians who treat children would be required to complete a minimum of four CME hours in how to recognize child abuse.
- **OSMA position:** OSMA opposes this bill.
- **Action taken:** Passed the Ohio House, sent to Senate for consideration.

House Bill 343 Immunity for Physicians Administering Pain Medication

- **What it does:** Provides im-

munity for physicians who administer pain medication to incompetent terminal patients, even though the medication appears to hasten death.

- **OSMA position:** Support
- **Action taken:** Passed the Ohio House, sent to the Senate.

House Bill 71 Prohibit Genetic Testing for Health Insurance

- **What it does:** Would prohibit the use of genetic tests for health insurance purposes. A last-minute amendment removed the prohibition against genetic test results in determining eligibility for life and disability policies.

- **OSMA position:** No position
- **Action taken:** Passed the Ohio House, sent to Senate.

Senate Bill 157 Mandates Insurance Coverage for Unapproved Cancer Drugs

- **What it does:** Would prohibit insurers from excluding or limiting coverage for cancer drugs used for unlabeled indications on the grounds they haven't been approved by the FDA for treatment of the specific type of cancer for which they are prescribed.
- **OSMA position:** Support
- **Action taken:** Received first hearing in the Senate Health Committee. ■

Two bills become law, others stall

Before recessing for the summer, the Ohio Legislature passed two bills into law.

Senate Bill 29 bans corporal punishment in public schools unless a school district adopts a policy expressly allowing its use. The new law, supported by the OSMA, becomes effective on October 17.

The governor also approved a measure allowing those prisoners sentenced to death the right to choose execution by lethal injection over electrocution. The law, which will become effective this fall, was closely monitored by the OSMA to assure that physicians would not be required to assist in executions. The present law has no statutory role for physicians in the lethal injection process.

Meanwhile, other bills have

Summer Legislative Report

become stalled, including three bills that would prohibit physician-assisted suicide – House Bill 18 and Senate Bills 7 and 9. Introduced quickly at the beginning of the year when Jack Kevorkian threatened to move his practice of assisted suicide from Michigan to Ohio, the bills have all remained in their original committees. HB 18 received several hearings in the House Judiciary Committee, but no consensus was reached. No hearings have been held yet on either of the Senate bills. ■

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How to become involved in the health reform process

As health system reform continues to be debated at federal and state levels, you may feel there is little you can do to make a difference in these discussions. But that's not true. Here are a few things you can begin to do now that will assure you some impact on the future of medicine:

1. STAY INFORMED

Learn about the Clinton reform plan. Find out as much as you can about it now, before it's released, but if your resources are limited, don't worry. Shortly after the release of the federal administration's health reform package, the AMA will be sending all physicians a summary and analysis – including the implications of the Clinton plan on your practice and your profits.

For news on state health-care re-

form, read *OHIO Medicine*. Issues regularly contain news about: the Ohio Health Care Board, which will make health reform recommendations for the state by January 1; the OSMA's Health-Care Reform Task Force, which hopes to have a reform package ready for legislators in the next month or two; as well as a new health reform proposal, drafted by Rep. Robert Hagan (D-Youngstown), who masterminded the old UHIO plan.

2. KNOW YOUR ELECTED OFFICIALS

This is no time to be guessing who represents you in Congress or at the Statehouse. The OSMA's Department of Legislation has sent all OSMA members a 1993 Legislative Directory. You should be able to find there the names, addresses

and phone numbers of your congressional representatives, as well as your state legislators. If you're unsure of your district, have not received a directory, or have questions, contact the OSMA's Department of Legislation – they'd be happy to help.

Once you've found out who your contacts are, establish a relationship with them. Introduce yourself as a physician and constituent. Write them, call them, fax them. Ask to meet to discuss health reform issues and what it means to patients. Attend meetings where your representatives and senators will address the public and ask questions. Call the OSMA and offer to testify on key issues. Attend the AMA National Political Education Conference in Washington next month. Become involved in the process.



3. GET YOUR MESSAGE ACROSS

Use your own words and experiences when discussing health-reform issues with your legislators.

Will people in your area have more or less access to quality care under a specific reform? Will you be able to provide more or less patient care?

Paint a picture, based on your experiences, for your legislator. Remember, politicians may know and understand policy, but physicians know patients and families – and what health system reform will mean to them. ■

Committees examine ways to reform Ohio health care

Over the summer, four committees and two subcommittees of the Ohio Health Care Board have met to tackle different aspects of health-care reform. The new board, created late last year by House Bill 478, has been charged with recommending ways to reform the state's health-care system by January 1 – a goal the board's executive director, Jackie Fullerton, is confident will be met.

The committees and subcommittees, along with their respective chairs and responsibilities, are listed here. Committees expect to wrap up their studies and discussions soon and report their findings to the full board this fall. *OHIO Medicine* will keep you posted on new developments with the Ohio Health Care Board as they occur.

ACCESS/FINANCING

Chair: John Hodges, labor representative

Responsibilities: This group is deciding what will be included in a health-care package, and how that package will be paid for.

COST DISCIPLINE

Chair: Sydney Zilber, consumer representative

Responsibilities: This group is examining how costs will be brought into the system once it is set up, and how they will be monitored. Among those items being considered are claims payments, co-pays and deductibles, and practice parameters.

DELIVERY SYSTEM

• **Property, plant and equipment**

Chair: William Ruse, hospital provider

Responsibilities: This group is considering all aspects of an ideal health delivery system, including rural vs. urban, public vs. private,

and what physical property would be needed to achieve this system.

• **Human resources**

Chair: Arnold Tompkins, Ohio Department of Human Services

Responsibilities: This committee is examining how care in this ideal system would be delivered and who would deliver it. They will address primary vs. specialty care, and the need for nurse-practitioners and other alternative health resources.

MONITORING AND QUALITY ASSURANCE

Chair: Claire Wolfe, MD, physician representative

Responsibilities: Theirs is a two-prong mission. First, members are considering how to effect quality assurance with all players in the health-care field, and second, how to maintain that quality once it is put in place.



SUBCOMMITTEE ON BASIC HEALTH CARE

Chair: William Porterfield, MD, HMO representative

Responsibilities: Determining what should be in the state's basic health-care package.

SUBCOMMITTEE ON MALPRACTICE REFORM

Chair: John Burry, insurer

Responsibilities: To discuss the need for tort reform, and what form that reform should take. ■

OSMA joins other groups seeking tort reform

The Ohio State Medical Association recently joined over 100 other state and national medical and specialty associations in imploring First Lady Hillary Rodham Clinton to include significant medical liability reform in any health system reform package announced by the White House.

In a letter addressed to the First Lady, the OSMA and the other supporting groups urged the Clinton administration to consider the Medical Injury Compensation Recovery Act (MICRA), enacted in California in 1975, over the concept known as "enterprise liability" in implementing tort reform.

"Nationwide application of... MICRA is the best proven reform



model available," the letter states. It urges the federal government to apply MICRA principles to all personal injury claims arising in the course of health care, and to encompass all potential defendants, including physicians, nurses and other practitioners, hospitals, managed care organizations and the producers of medicines and medical

devices.

Under "enterprise liability," all risks are shifted away from the practitioner and toward the "enterprise" — be it hospital, managed care plan or the like. The letter states that this concept is unproven and will not correct fundamental deficiencies in the tort system.

"Investigation of alternative dis-

pute resolution, pretrial screening mechanisms and legal uses of practice parameters may all be warranted," the letter continues. "However, no health reform package will be satisfactory to the undersigned organizations if the MICRA reforms are not included."

The OSMA's Task Force on Health-Care Reform is also considering the matter of tort reform as part of the health-care reform package they will take to the Statehouse later this year. Watch *OHIO Medicine* for news about further developments in the area of tort reform. ■

Popular Tort Reform Principles

According to a letter that was sent to First Lady Hillary Rodham Clinton, tort reform's "gold standard" is legislation known as the Medical Injury Compensation Recovery Act, which was enacted in California in 1975. Here are some of that law's guiding principles:

- Caps on non-economic damages
- Limits on lawyers' contingency fees
- Structured settlement payments for large awards
- Collateral-source rules that deduct a victim's insurance payments from any award.

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PRESIDENT'S PERSPECTIVES

"Hey Walt" responds to reader input

Many thanks to all of you who took time to express your ideas and concerns on the "Hey Walt" cards included in the May issue of *OHIO Medicine*. I have read them all and have already responded to some of you and intend to respond personally to several more. Obviously, it would be impossible to answer each and every one of you. Rather, over time, I would like to use this monthly column to address the several large issues you collectively raised.

HEALTH-CARE REFORM

Most of you, in some way, expressed concern, uncertainty, frustration and even anger with the issues addressed in the current health-care reform controversy. The OSMA Task Force on Health-Care Reform has been actively formulating a reform plan representing a consensus viewpoint of Ohio physicians. Hopefully, the task force report will be ready by early fall.

WHO'S RUNNING OSMA?

Several young physicians expressed concern over their perception of control of the OSMA by older, "retired" physicians. They feel that young physician participation is not solicited or appreciated. I agree this is an important issue. Be it perception or reality, I have begun researching the age distri-

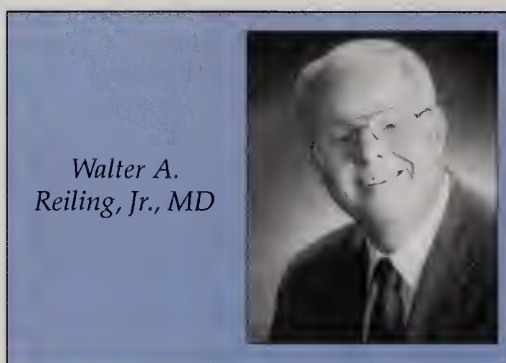
bution of our governing body and AMA delegation. I hope to see if we can demonstrate a trend. (See next month's column.)

LICENSE FEES

Finally, I was very surprised at the large number of respondents who expressed deep concern over the proposed increase in physicians' licensure fees. Many asked the OSMA to strongly oppose any and all fee increases. Others were equally disturbed over the fact that the medical board only receives a portion of the fees collected. The remainder is considered general revenue. Stated simply, physicians resent what they view as a hidden and discriminating tax.

We need to discuss the license fee issue in depth. Currently, you and I pay \$160 every two years to exercise our licensure privileges. This level was set in 1991. Two years earlier, Rep. Rhine L. McLin (D-Dayton) proposed a fee increase from \$100 to \$300, but that proposal never passed. Then, in 1992, HB 478 contained, for a time, a \$50 increase in fees. All of this money, however, was to be earmarked to repay student loans for young physicians willing to practice in certain designated, underserved

areas. The OSMA supported the physician loan repayment program, but although the program was retained in the bill, money to



Walter A.
Reiling, Jr., MD

fund it failed to survive the legislative process.

Finally, early this year, the Ohio State Medical Board told legislators they needed a fee increase to \$300 and a rotary fund that would return all the monies to the medical board. They made this proposal without consulting or informing either the OSMA or the Ohio Osteopathic Association (OOA), even though we have repeatedly expressed our willingness to cooperate and support the board. The OSMA argued that such a significant increase was unjustified and duplicative, but legislators focused on physician incomes and their ability to pay the increase. In the end, legislators passed an increase to \$250, but did create a special account for the board so license

money would not be placed in the state's general revenue fund. A portion of the increase has also been earmarked for the student loan repayment program.

I believe the medical board needs more funding. They are woefully understaffed, and some of the physical equipment is hopelessly outdated. The only question is, How much of their budget is needed and how much, if any, represents fluff? Let me cite two examples to illustrate my point.

First, there is a large line item dedicated to "physician education." It seems to me the OSMA, OOA, medical schools, specialty societies and other organizations already fulfill that function and happily cooperate with the board. Secondly, a significant segment of the budget would be devoted to investigating the diversion of legal drugs for illicit purposes. You will soon note a huge increase in your federal narcotics license (DEA) fee, allegedly to study the same problem. I do not believe physicians are the sole or even primary source for drug diversion. What about pharmacies, hospitals and others? Why should we support the cost alone? Why don't we have a coordinated effort? Our local law enforcement agencies, our medical boards and the DEA seem to be attacking the problem independently at our expense. Think about it! ■

ALLIANCE REPORT

Fall meeting promises variety

By Barbara Mattes, Lucas County

The OSMA Alliance has scheduled a Fall Focus Meeting on September 21-22 at the Maumee Bay Resort on Lake Erie, east of Toledo. Participants will have two new health projects introduced to them over the two-day period, along with programs bringing us new perspectives on life.

On the evening of September 21,

Trumbull County will present a successful program, "Art in the Hospital," which brought masterpiece posters and original pieces of art by local artists into the hospital for both patients and visitors to enjoy. For many, this project may have provided a first encounter with classical painting. In addition, details of an anti-smoking program, currently in effect in the schools of Toledo, will be presented

on September 22 by Murray Howe, MD, a member of Doctors Ought to Care. DOC is interested in expanding the program throughout the state of Ohio.

On a personal level, Alliance members will have the opportunity to share views about the medical marriage with author Esther Nitzberg. Her controversial book, "Hippocrates Handmaidens, Women Married to Physicians," has

caused mixed reactions amongst its readers.

Scott Sheperd, PhD, will discuss an uplifting, positive approach to life. Dr. Sheperd's program, "Re-kindling the Spirit," has provided insight to avoiding self-defeating behavior patterns.

The Fall Focus Meeting is open to all Alliance members. Registration inquiries may be directed to Carol Wenger at OSMA-A headquarters. ■

SECOND OPINION

Dear Patient: What's wrong with this picture?

By Vladimir Swerchowsky, MD

Another example of further harassment of physicians has tested the limits of my tolerance. Therefore, I have sent my patients the following letter. I hope you find it interesting.

Dear Patient:

As a courtesy to you and with an eye toward good medical practice, I have been in the habit of passing out stool slides once a year so that you may have your stool tested for blood on a yearly basis – in order to facilitate colon cancer screening and simply to look for blood, which shouldn't be there.

The HCFA (Health Care Financing Administration) has decided that, since my office has performed such functions in the past, the Clinical Laboratory Improvement Amendment (can you believe that) of 1988 provisions apply to my "office laboratory."

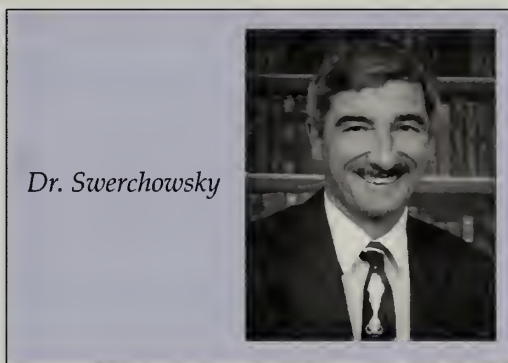
Because of the above, I have in front of me a stack of forms to be

filled out, along with a "user fee remittance" for \$100, which is to be paid for the privilege of doing such a test through the office.

Medicare has reimbursed my office in the past for the sum of \$3.69 for this test. Fifty such slides with a convenient mailing pouch, also mandated by law, cost this office \$139.60, which means that one set of slides costs \$2.79. If I mail you those slides, add 29¢. Of course, it also costs something to have someone in the office order them, send them, test them, record the results, put it in the file, bring it to my attention, contact you with the result, send you a letter if the test is abnormal and remind you to follow it up, plus the cost of filling out Medicare forms. The true cost of performing this service as a courtesy is far greater than the \$3.69 that Medicare has reimbursed.

I have been willing to absorb that as a courtesy to all of you, however

I must draw the line here. I just cannot swallow another thinly disguised tax for doing something that, to me, comes naturally –



Dr. Swerchowsky

which is to practice good medicine and, in this case, preventive medicine. This is just one of many ways in which the government has interfered with good medical practice.

My advice is still the same. You should still have your stool tested for blood on a yearly basis, but it cannot be done through my office.

If you think there is something wrong with this picture, please complain as loudly as you can to

your government and mine. Please write your state senator, your congressional representative, and to Bill and Hillary Clinton.

There are many tests that can and, in fact, should be done in a physician's office. Many of these will not only save you time, but will get you a faster diagnosis and, as a result, better medical care. Unfortunately, your government and mine doesn't think so. It is the government's position that doctors cannot be trusted. It is my position that, when it comes to health care, we cannot trust the government to act appropriately in your best interest. I will be sending a copy of this to President Clinton and to Hillary Clinton's committee. As you know, however, they will not listen to me, but they may listen to you.

Sincerely,

Vladimir Swerchowsky, MD

Dr. Swerchowsky practices cardiology in Lakewood.

OHIO Medicine

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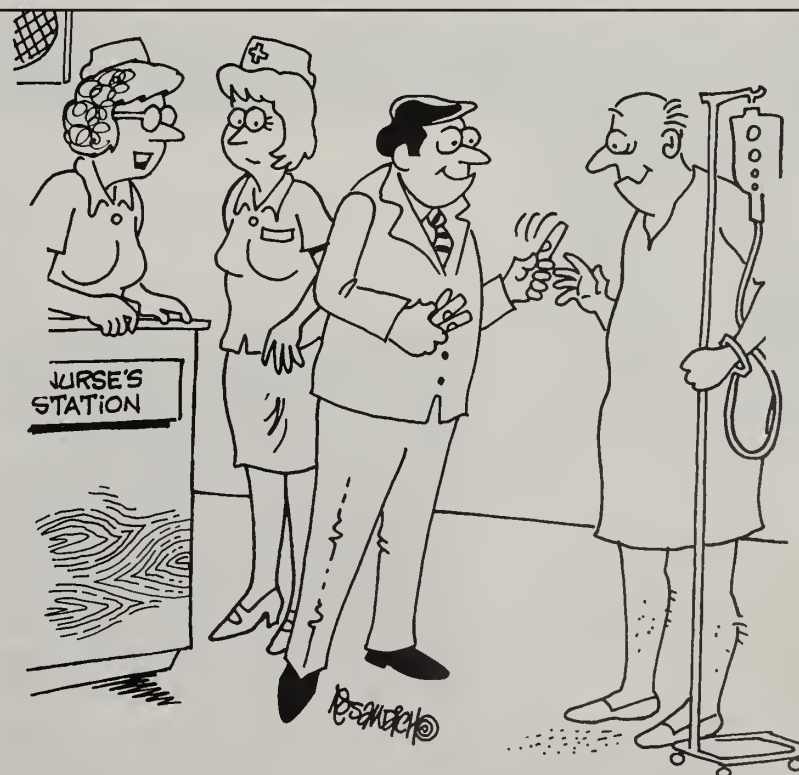
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"No, Dr. Fox's wife didn't have a baby...he finally paid off his student loans."

LETTERS TO THE EDITOR

Editor's Note: The following letters all ask for your assistance on various projects or studies. Please contact the number given in the letter for more information. OHIO Medicine has no further details.

Airbag education

To the Editor:

On behalf of Morton International, the leading producer of airbags for automobiles, we are engaged in an airbag educational program for consumers.

As part of our program, we are conducting extensive research to locate people who have had airbag-related experience, including doctors, emergency medical personnel and crash survivors.

If you have information, please contact Paula Goldstein, (212) 575-1976 or write to Geltzer and Company, Inc., 1180 Sixth Avenue, New York, New York 10036.

PAULA GOLDSTEIN
Geltzer and Company, Inc.
New York

Russian impotence center

To the Editor:

Recently, I received a letter from two Russian urologists who are requesting assistance in establishing an impotence center in their republic. They indicate that many men in their community were called upon to assist in the clean-up operations at Chernobyl, and became impotent largely as a result of radiation exposure. Their situation is particularly urgent since they have over 3,000 patients and no therapy available to them. Twenty-two patients, all 30-35 years of age, committed suicide last year because of sexual dysfunction and the lack of any available treatment. The logistical problems in trying to provide any substantial amount of medical aid to Russia are enormous. The Russians currently have no effective treatment

available and little or no experience in impotence testing or treatment. The Russian government does not consider impotence a high medical priority and they don't have any funds available to purchase medical equipment or supplies. Even if adequate resources are provided, there is no guarantee that they would actually reach the intended Russian medical facility.

Nevertheless, we believe that these problems can be solved if enough interested people and organizations are involved and combine our expertise, knowledge and resources. If you or your organization can provide any kind of assistance or advice, please contact me at the address below or call (216) 246-4000. Thank you for your consideration and help.

STEPHEN W. LESLIE, MD
Medical Director, Lorain Impotence Center
221 West 21st Street, Lorain, OH 44052

Relief mission to Russia

To the Editor:

The National Vietnam Veterans Coalition Foundation is looking for volunteers for a series of medical relief missions to the former Soviet Union during the next two years. Volunteers must pay their own airfare (tax deductible) and commit to a week to 10 days of service. Food and lodging are provided by the former Soviet Republics, which also guarantee physicians' safety. The missions are being organized by Edward Artis, a West Hills television/film producer and decorated Vietnam medic. In addition to volunteers, Artis needs medical supplies and drugs. For more information, call him at (818) 888-5562.

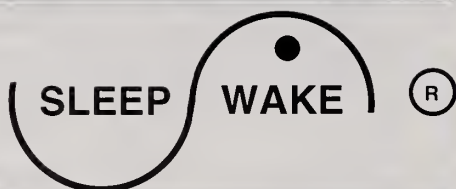
The physician volunteers who have participated in these medical missions have provided much-needed treatment to hundreds of grateful patients. As a wounded Vietnam veteran, I benefited from the immediate attention of skilled American MASH surgeons that was not available to our Russian colleagues. Sharing our medical skills and technology now permits us, as a people, to treat not only physical wounds, but those that have divided our nations in the past.

TERRY L. MARIS
Dean, Ohio Northern University
Ada

A Good Night's Sleep Is Not A Luxury, It Is A Necessity!



Helmut S. Schmidt, MD, ABPN, ABSM
Dr. Schmidt, founder of the first Sleep Medicine Clinic in the Midwest to be accredited, directed the National Examination to certify Sleep Medicine Specialists from 1980-1991 and was the first president of the American Board of Sleep Medicine. Long-time contributor to sleep, he was awarded the Kleitman Prize in 1988, the highest award in Sleep Disorders Medicine.



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Viewpoint

Drive at age 14?

Whenever we read of another teenage auto accident, our immediate reaction is that the driver should be punished and the driving age raised, but teenagers are more inexperienced than just reckless.

No one expects to play a piano, speak a language or learn to type with only six hours of instruction and eight hours of practice, but that is what we do with the automobile. I feel that driving is not to be learned in days or weeks; one needs months of practice.

I would allow a 14-year-old, after a driver's training course, to

drive in the daytime if accompanied by a licensed adult. After a minimum number of hours are logged, like an airplane pilot, they could drive at age 15 at night with a licensed adult. Full licensure would be granted at age 16 or 17 if they accumulated enough total hours.

What's your opinion?

W.B. Rogers, MD
Cuyahoga Falls

Write to:

Editor, OHIO Medicine
1500 Lake Shore Dr.
Columbus, OH 43204-3824

OSMA salutes outstanding team physicians

Five Ohio physicians were honored by members of the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, Ohio High School Athletic Association, and the Ohio Athletic Trainers Association at last month's Outstanding Team Physician Awards held July 15 at the Four Winds Restaurant in Canton.

Those honored included: Robert J. Herman, MD, Wapakoneta; Robert R. Roberts, MD, Akron; Charles D. Stienecker, MD, Wapakoneta; Karl F. Wieneke, Jr., MD, Youngstown; and V. George Zochowski, DO, Pataskala.

MANY UPS, FEW DOWNS

Dr. Herman served for more than 20 years as team physician for Wapakoneta High School. During that time he has kept the health and well-being of the young athletes as a top priority. However, Dr. Herman's own health and well-being was once compromised during a game when he was accidentally tackled as he stood on the sideline.

Dr. Herman is past president of the Auglaize County Medical Society. He served as physician for the county home for 40 years and as medical director for the Wapak Manor Nursing Home for 20 years.

FORMER ATHLETE

Dr. Roberts has served the St.



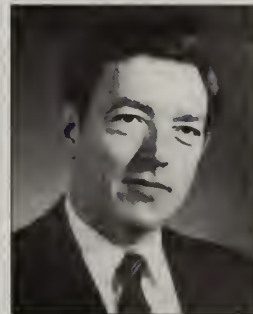
Dr. Herman



Dr. Roberts



Dr. Stienecker



Dr. Wieneke



Dr. Zochowski

Vincent-St. Mary High School athletic program for the past 28 years. The internist says the most life-threatening injuries he encountered as a team physician were a ruptured kidney requiring emergency nephrectomy and a ruptured spleen that occurred in a junior varsity game he happened to be visiting.

A native of Akron, Dr. Roberts participated in football and basketball throughout his scholastic career. He serves on three hospital staffs and formerly served as internal medicine preceptor for the family practice residency program at Barberton Citizens Hospital.

MEDICAL BOARD MEMBER

Even while serving on the Ohio State Medical Board, Dr. Stienecker found time to help Wapakoneta High School athletes. He also finds time to serve as medical director for the Wapakoneta Volunteer

Emergency Medical Service, and is an active member of the OSU Alumni Band.

In reflecting on his 25 years as team physician, Dr. Stienecker says, "My greatest personal rewards have come from helping young people overcome adversity and personally triumph to play again."

LABOR OF LOVE

"Being a team physician has been a labor of love for me," says Dr. Wieneke recalling his years as a team physician at Cardinal Moonhey High School in Youngstown. "It has been personally rewarding, and I've enjoyed the camaraderie and friendship of the students and coaches," he says.

Dr. Wieneke says the most rewarding aspect of long-time service – 24 years in his case – is to follow the developing careers of the young student athletes and to

see so many become outstanding business and professional people.

Dr. Wieneke practices general and oncologic surgery, plus head and neck surgery, in Youngstown.

TRUSTED FRIEND

Words like "trusted friend" and "doctor of rare quality" appear throughout Dr. Zochowski's letters of recommendation.

Dr. Zochowski has served as team physician for Watkins Memorial High School for 20 years. For several years, he sponsored a scholarship for student athletes.

"I enjoy sharing the players' joy of winning, disappointments of losing, and just being present to lessen their pain when an injury occurs," says Dr. Zochowski.

Dr. Zochowski is a family practitioner in Pataskala.

Congratulations to all of this year's recipients. ■

Colleagues

ELI C. ABRAMSON, MD, Toledo, was named Riverside Hospital's Physician of the Year. Dr. Abramson is director of medicine at Darlington House.

IAN J. ALEXANDER, MD, Akron, received the Humana Award for Excellence from the American Orthopedic Foot and Ankle Society. Dr. Alexander, of Orthopedic Surgeons, Inc., was honored for his clinical research leading to advances in the treatment of foot and ankle disorders.

ROBERT BARNETT, MD, Defiance, was named chief of the medical staff at Defiance Hospital.

Dr. Barnett specializes in family medicine.

GEORGE H. DIETZ, MD, Youngstown, received the Distinguished Physician award from the Mahoning County Medical Society and was named a Man of the Year by the Youngstown YMCA.

Dr. Dietz, a retired plastic surgeon, is a past president of the society, a founding member of the International Society of Clinical Plastic Surgeons and an associate professor at NEOUCOM.



Dr. Dietz

ERIC B. FISHER, MD, Lima, was awarded St. Rita's Medical Center's first Excellence in Medicine award. Dr. Fisher has a private practice in internal medicine.

GEORGE HARDING, IV, MD, Columbus, was voted president-elect of the National Association of Psychiatric Health Systems. Dr. Harding is president of Harding Hospital.

MARVIN KOPELSON, MD, Cleveland, was elected chief of staff at Meridia Euclid Hospital.

IGNACIO G. LAHORRA, MD, Cleveland, received the Clinician of

the Year award from the The Academy of Medicine of Cleveland. Dr. Lahorra, director of the division of family practice at MetroHealth Saint Luke's Medical Center, also maintains a private practice.



Dr. Lahorra

MARCUS OSWALD, MD, Cincinnati, was elected president of the Hamilton-Fairfield Area Academy of Medicine. Dr. Oswald is a radiologist practicing at Fort Hamilton-Hughes Memorial Hospital. ■

Members see greater need for OSMA in the future

Nearly three-fourths of the delegates and alternates queried at the 1993 Annual Meeting in May felt that there will be greater need for the OSMA in the next five years.

The 22-question survey was

conducted as part of the OSMA's annual survey of members on activities and performance of the association.

Most physicians surveyed were active in at least five professional

associations, but 65% ranked their OSMA membership as "most" or "very" valuable compared to other associations. Unfortunately, the majority also felt there was at least a fair amount of duplication of

effort among medical societies – county, state, national and specialty. Overall, 94% of the respondents had a "very" or "somewhat" favorable attitude toward the OSMA.

Ninety percent of the 72 who responded were males in a group practice, had practiced more than 20 years and had been a member of the OSMA for more than 12 years. Almost half represented the city or metropolitan area and were between the ages of 45 and 60.

PROBLEM-SOLVING RANKS HIGH

OSMA received high marks in solving important problems of its membership, as well as in communicating with its members.

When delegates were asked to rate OSMA services to other professional associations, topping the list were government relations (lobbying), followed by the executive staff's understanding of members' problems and third-party relations (ombudsman).

Although 38% responded that they had no problems in dealing with the OSMA, 18% did say that differing points of view among members cause conflict or lack of cooperation, and 15% felt that services are designed for a dominant section of the membership.

DUES "REASONABLE"

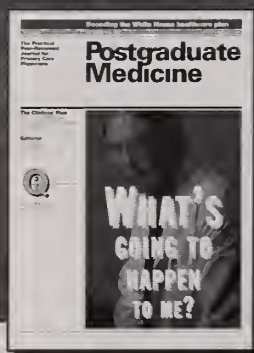
At the present time, 74% of physicians felt the current OSMA dues were in line with the services provided and that the dues structure was fair to all types of members (78%). However, when asked about any increase, 46% responded they would not like to see an increase, with only 28% favoring a \$10-\$20 hike.

In the past year, 98% of those surveyed had at least some contact with the OSMA and reported that the staff was very responsive to members' needs. More than half (58%) felt the elected leadership of the OSMA was doing a good job.

A similar survey of new members and a random-sample of current members will be conducted for comparison. The OSMA Department of Membership will use this information to see what changes can be made to better meet the needs of the membership. ■

THEY HAD A MEETING TO DECIDE YOUR FUTURE... AND YOU WEREN'T INVITED

Read the September 15th and November 15th issues of POSTGRADUATE MEDICINE to get details of the Clintons' healthcare plan and to learn how it will affect you and what you can do about it.



Highlights from the AMA meeting

First Lady Hillary Rodham Clinton knows how to play to an audience. In a tailored-made speech to physicians at the AMA Annual Meeting in June, she told the profession what it wanted to hear.

While physicians applauded politely, some were skeptical. Clinton avoided many of the controversial subjects and never discussed specifics of the administration's proposal on reforming the nation's health-care system.

The first lady's attendance, along with the issue of gay physicians' membership in the AMA, attracted considerable media attention. The AMA House of Delegates have battled for several years whether to amend the bylaws to include "sexual orientation" to the list of protected categories such as age, race, gender, national origin, religion and disability. This year, however, the tide turned. After pleas from gay and lesbian physicians, the AMA bylaws now will specifically bar discrimination in membership based on sexual orientation.

NEW RBRVS POLICY

In another reversal, the AMA delegates decided to back away from their disapproval of a prospective payment system and to approve a new policy encouraging private insurers to base physician payments on a resource-based relative value system (RBRVS), but one that contains none of the imperfections of the current Medicare system.

Managed care and other payors could use adjusters to the standard RBRVS in developing payment schedules to reflect access and other concerns, but only negotiations with the physicians participating in their health plans.

Unlike Medicare, this plan would not force the physician to accept payment in full without a contract to do so. Physicians could base their fees on a conversion factor determined by the physicians' assessment of their overhead and the market value of their services. The AMA board will report back with specifics for implementing this policy at the interim meeting in December.

OHIO RESOLUTIONS FARE WELL

The Ohio delegation fared well with four of the five resolutions they brought to the AMA. Following are the outcomes:

- Timely transfer of patients to extended care facilities was adopted. It asked the AMA to develop a working group with representatives of appropriate health-care organizations and federal agencies to address the problem of transferring patients to extended care facilities on weekends and holidays.
- The House adopted a substitute resolution asking that the AMA support keeping HIV infection on the list of communicable diseases of "Public Health Significance" for purposes of immigration law and that the AMA reaffirm its position of mandatory testing of all immigrants for HIV infection and excluding those who are infected from settling permanently in the U.S.
- After adopting the Smoking in Teenage Females resolution, the AMA was asked to work with the AMA Alliance to develop and implement programs to educate youth about the dangers of smoking.
- The practice parameters resolution was referred to the Council on Medical Services. The AMA will develop a mechanism through the CMS to act as the coordinating body to collate, analyze, distill and rank the recommendations of parallel parameters of various organizations and to develop one or more mechanisms that will disseminate the final, extracted and ranked practice parameters to all practicing physicians.
- The AMA did not adopt the resolution to support development of a CPT code modifier to describe physician office laboratory procedures. Testimony indicated that it is too expensive to maintain an office lab and that reimbursement is not adequate under CLIA.■

CALENDAR

The OSMA, in association with Conomikes and Associates, Inc., has planned the following practice management workshops for 1993.

Young Physicians – Practice Management Seminars

Winning Investment Strategies for the '90s and Beyond – A half-day financial planning workshop teaching the principles of investing and ways to apply these principles to your own portfolio.

Financial Control of Your Practice in 30 Minutes a Day – This two-hour workshop outlines steps participants can take to gain control over their finances without sacrificing time with patients.

Sept. 21 Holiday Inn, Worthington
Sept. 22 Marriott Airport, Cleveland
Sept. 23 Youngstown Club, Youngstown

How to Run a More Profitable Practice

This one-day workshop is designed to show you the steps to a smarter, leaner and more profitable practice. Learn where your trouble spots are and how to bring them under control.

Sept. 28 Marriott Airport, Cleveland
Sept. 29 Concourse Hotel, Columbus
Sept. 30 Marriott, Cincinnati

Maximizing Your Collection Results

This one-day course is designed for the experienced office manager, billing supervisor and physician manager. The course deals with all aspects of the collection process. Learn to identify the problem, correct it and make certain it doesn't return. The workshop approaches the collections function from the management perspective.

Oct. 12 Dana Center at MCO/Hilton, Toledo
Oct. 13 Sheraton City Center, Cleveland
Oct. 14 Parke Hotel, Canton
Oct. 26 Concourse Hotel, Columbus
Oct. 27 Stouffers, Dayton
Oct. 28 Sheraton, Springdale, Cincinnati

The following are sponsored in cooperation with the AMA's Financing and Practice Services Inc. and the AMA Investment Advisers Inc.

Gearing Up For Retirement

Nov. 9, 10 Columbus Hilton North, Worthington

Starting To Practice Smart

Nov. 10, 11 Columbus Hilton North, Worthington

Joining A Partnership or a Group Practice

Nov. 12 Columbus Hilton North, Worthington

County Notes

■ Trumbull County

Trumbull County Medical Society members are taking pen in hand in an effort to promote a more positive community-minded view of physicians. Articles written by members are turning up in the *Tribune Chronicle* on a monthly basis. The articles began running the first week of July.

Members were asked to submit a page-and-a-half article about their particular speciality. So far the response from physicians has been good, according to Marie Persin, executive director of the Trumbull County Medical Society. This public service campaign is an alternative to the mini-internship program previously sponsored by the society.

According to Persin, "the five-year-old internship program had run its course in a community the size of Warren." The new

public service campaign garners much-needed positive visibility for the medical society as well as the individual physician, and is less expensive to administer than the mini-internship program

■ Summit County

Since local historical medical information was often scarce and scattered the Summit County Medical Society decided to do something about that.

To mark the 150th anniversary of the founding of the Summit County Medical Society, Sid Mountcastle, executive vice president, has put together an interesting historical summary of the organization after months of research, utilizing meeting minutes and historical accounts from historians of the society. If interested in obtaining a copy, contact the Summit County Medical at Society, (216) 434-1921.



Golfers Tee Off

Cambridge and Guernsey counties were represented at the 1993 Ohio State Medical Golfers Association Tournament at the Country Club of Ashland in June by, from left, Emmanuel D. Noche, MD, Jesse B. Kellum, MD, Howard D. "Bud" Miller, MD, and Robert L. Chess, MD.

Membership receives award

Doug Evans, director of the OSMA Department of Membership, accepted a "Pinnacle of Success Award" July 31 in Boston from the American Association of Medical

Society Executives.

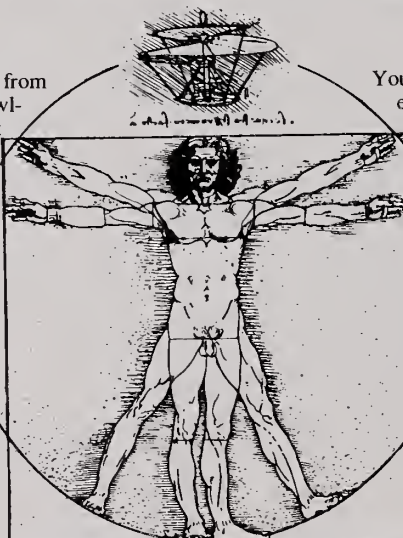
The OSMA won the national award for its outstanding 1992 membership program. ■

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AIM HIGH

AIR FORCE

Academic doctors want own voice in organized medicine

Academic physicians have unique problems that are not being addressed within the scope of organized medicine. That was the message recently delivered in a focus group interview conducted with eight physicians at the Ohio State University College of Medicine by the OSMA Department of Membership.

"Unfortunately, the academics believe that organized medicine and practicing physicians have not given them equal opportunity to express the 'academic' opinion on issues affecting medicine," says Doug Evans, director of OSMA's Membership Department.

Academics feel they are a minority in the traditional setting of organized medicine, and they are frustrated by the lack of an organization that specifically meets their needs. In fact, they say, organized medicine frequently lumps them into a hospital medical staff section for lack of a better place to put them.

Academic physicians historically believe that organized medicine has focused on the needs of the practicing physician at the expense of the teaching physician. Because they also maintain a clinical practice, academic physicians don't want to see organized medicine discontinue its traditional focus, but they would like to see that focus expanded to include the interests of those in teaching institutions.

RIGORS OF ACADEME

Academic physicians do have unique problems – a heavy teaching load, pressure to publish, difficulty prioritizing demands from deans, clinical practice, students and others – yet they receive little support either from the medical profession or from other academics.

What they would like is a committee or special section that could discuss and take issue, if necessary, with medical matters that have an academic perspective.

The participants also welcomed the idea of better and closer relations between the academic community and the OSMA. They suggested more participation and cooperation from the academic deans

and faculty.

"The discussions identified the differences in needs and wants between practicing physicians and academic physicians," says Evans. "Our intention is to use the infor-

mation to formulate specific benefits and services solidifying and/or increasing OSMA membership among academic physicians."

The OSMA Committee on Membership Marketing, as well as the

OSMA Council, will study the results from the focus group and consider what role OSMA will play in tapping into the academic market. ■

The Merits of Membership:



OBJECTIVE FINANCIAL CONSULTATION.

With the financial changes that are occurring in the medical community, it has become even more important to have your financial situation objectively reviewed.

OSMA has developed a program that ensures the information and advice you receive is relevant to your unique financial situation.

This OSMA membership benefit, available at no additional cost, will help you maximize your earning capabilities both now and after health care reform.

For more information, call John Mayer at 1-800-766-OSMA

Elder abuse campaign gears up

The third and last part of the OSMA's family violence campaign dealing with elder abuse is scheduled to kick off in November.

In the meantime, the OSMA has met with, and applied for a grant

from, the Ohio Department of Human Services. As of this writing things look promising, according to Carol Mullinax, director of the OSMA Department of Communications.

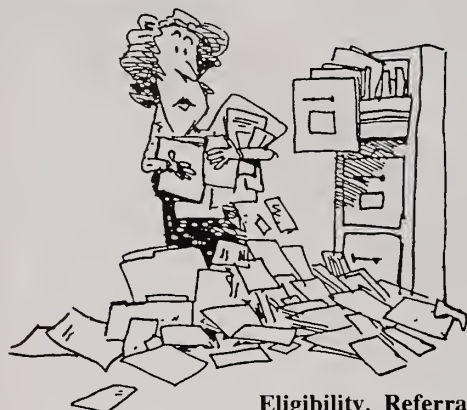
This campaign follows on the heels of two successful campaigns – domestic violence, which was launched last October, and child abuse, which kicked off in April.

Once again an educational hand-

book will be developed, which will include clinical guidelines, legal considerations and a list of county agencies to which physicians should report elder abuse.

A task force on elder abuse has been formed to review appropriate material for the handbook. Serving on the committee are: Patty Whisman, MD, Newark, chair; Georgia Anetzberger, PhD, Cleveland; James W. Campbell, MD, Cleveland; and Tarlok S. Purewal, MD, Marion.

OHIO Medicine will keep you posted on further developments on the elder abuse campaign. ■



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Cheryl Sullivan, Western Ohio Health Care Plan, (513) 436-8857 or (800) 644-5465

County execs meet OSMA staff

Executives of county medical societies from across the state convened last month at Salt Fork State Park Lodge for the annual OSMA Society Executives Meeting.

"The Council of the OSMA firmly believes that the continuing, excellent relationship between the county medical societies and the OSMA is critical to the ongoing success of organized medicine in the state," says Brent Mulgrew, OSMA's executive director. "The meeting gives our county executives the opportunity to meet and discuss current issues with colleagues and the state staff in a cooperative spirit."

The focus of this year's meeting was health-care reform, and included talks on that topic by AMA's field representative David Porter, and Jackie Fullerton, executive director of the Ohio Health Care Board. In addition, OSMA staff members discussed the emergence of physician-hospital organizations, and county society executives from Cleveland, Toledo, Summit and Lake Counties discussed health reform from the county society perspective.

"Once again, the tradition of a successful meeting was met," says Mulgrew. "Both the county executives and the OSMA staff walked away with a better understanding of the issues that face medicine, and what we can do to meet the needs of our physician-members." ■

Family/Medical Leave Act may affect some physicians

If you're a physician in a practice with 50 or more employees, you must now adhere to the Family and Medical Leave Act (FMLA).

The act, which becomes effective August 5, allows qualified employees up to 12 weeks of unpaid leave per year for the birth or adoption of a child, to care for a spouse, child or parent with a serious health condition, or when the employee is unable to work because of a serious health condition.

If covered by the FMLA, the employer must maintain any pre-existing health benefits for the employee during the leave period and must reinstate the employee in the same or equivalent position upon return.

PHYSICIANS' APPROVAL NEEDED

Besides following the law in their own offices, physicians will have another responsibility – filling out medical certifications that employers may require of their employees.

Under the FMLA, employers may require a health-care provider to attest that the employee is too seriously ill to work or that a family member is seriously ill and requires the care of the employee (if dissatisfied by the original certification, an employer may, at its expense, request a second or third medical opinion).

A form that has been developed by the Department of Labor contains entries for the following:

- 1). The date the health condition began and likely duration;
- 2). Diagnosis;
- 3). Treatment prescribed for the condition, including number of visits, nature, frequency, etc.;
- 4). Whether hospitalization is necessary.

If the employee requests medical leave because of his or her own illness, the certification must also include a statement that the employee is unable to perform the essential functions of his or her position.

If the employee requests medical leave because of a family member's

illness, the certification must include a statement that the patient needs help fulfilling basic medical, hygiene and nutritional needs.

In addition, if the employee requests additional time off, the

employer may request recertification, (though not more often than every 30 days), if the circumstances surrounding the illness change or the employer has reason to doubt the validity of the previous certifi-

cation.

Although the certification forms were not available at press time, *OHIO Medicine* will keep you updated. ■

*The Merits of
Membership:*



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Physicians are ineligible for 85% of the health insurance plans on the market today. However, we have a database of health insurance carriers that identifies which plans cover physicians.

This information, which you can receive directly over the telephone, is an OSMA membership benefit at no additional cost.

For more information, call John Mayer at 1-800-766-OSMA

MEDWatch makes reporting of medical reactions easier

Physicians whose patients experience adverse medical reactions or even death as a result of using drugs or medical devices now have an easier time of reporting such events.

The Food and Drug Administration (FDA) has introduced MEDWatch, a reporting system much improved over the old.

In the past, says FDA Commissioner David Kessler, in a recent article in the *Journal of the American Medical Association*, physicians have not always viewed reporting adverse reactions as crucial. "What this is about is trying to change the culture of medicine so that reporting products that cause harm becomes a part of it," he says.

"Right now the average physician doesn't even know there's a system in place for reporting," he says, adding, "That has to change."

Although drugs and medical devices undergo rigorous testing

by the FDA before they're approved for the public, Kessler notes that if a dangerous reaction occurs in 1 in 1,000 patients, it could be missed in studies but become a health hazard to the general public.

The reporting of adverse medical reactions is voluntary, and Kessler notes that it has been estimated that only 10% of serious reactions are currently reported, with one study estimating that figure at only 1%.

To emphasize the importance of physicians filing such reports, Kessler cites the recent pulling of silicone gel breast implants from the general market: "If reports from physicians who diagnosed autoimmune-like disorders in patients with breast implants had been received years ago, the possible connection might have been identified much earlier."

Physicians who document an adverse medical reaction should

submit the new, one-page report (see sidebar for guidelines), which has been printed in the *Physicians' Desk Reference*, the *FDA Medical Bulletin* and the *AMA Drug Evaluations*. If physicians need to obtain a form, they should call 1-

(800) FDA-1088, seven days a week, 24 hours a day. The reports, which protect physician confidentiality, may be faxed to 1-(800) FDA-0178 or filed electronically by calling 1-(800) FDA-7737. ■

When to Report Adverse Reactions

The Reports Pertain To:

- Medications
- Medical devices
- Nutritional products (dietary supplements, infant formulas)
- Other products regulated by the FDA

Serious Adverse Reactions:

- Death
- Life-threatening
- Hospitalization

- Disability
- Congenital anomaly
- Required intervention to prevent permanent damage

Numbers to Call:

- 1-(800) FDA-1088 – For more information
- 1-(800) FDA-0178 – To fax a report
- 1-(800) FDA-7737 – To report electronically

What Ohio doctors need to know about prescribing drugs

By Anand Garg, MD and Joan Wehrle

Editor's Note: The following article originally appeared in the Mahoning County Bulletin. It has been edited and will be reprinted here in two parts. This month, the statutes and rules regarding prescribing drugs in Ohio are discussed. Next month, several disciplinary actions taken last year by the board and relating to prescribing will be reviewed.

Three statutes of Ohio law provide a framework for drug-related grounds for discipline by the Ohio State Medical Board. These are:

SECTION 4731.22 (B) (2), ORC

Failure to use reasonable care in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease.

Some often-seen examples of violations of this statute include:

- prescribing controlled substances without medical indication
- excessive prescribing

- prescribing to addicts

SECTION 4731.22 (B) (3), ORC

Selling, prescribing, giving away or administering drugs for other than legal and legitimate therapeutic purposes, or a plea of guilty to or a judicial finding of guilt of, a violation of any federal or state law regulating the possession, distribution or use of any drugs.

SECTION 4731.22 (B) (6), ORC

A departure from or a failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established.

In addition to the statutes, the medical board adopted administrative rules regarding the use of controlled substances in 1986 in response to problems of widespread overutilization and inappropriate use of controlled substances. Key provisions of the rules include:

RULE 4731-11-02 (C), OAC

A physician shall not utilize a

controlled substance without taking into account the drug's potential for abuse, the possibility the patient will obtain the drug for a non-therapeutic use or to distribute to others, and the possibility of an illicit market for the drug.

RULE 4731-11-02 (D), OAC

A physician shall complete and maintain accurate medical records reflecting examination, evaluation and treatment of all patients. Patient medical records shall accurately reflect the utilization of any controlled substance in treatment and shall indicate the diagnosis and purpose for which the controlled substance is utilized and any additional information upon which the diagnosis is based.

Here are the key provisions of the rules:

- Take into account the drug's potential for abuse.
- Consider the possibility the drug may lead to dependence.
- Consider the possibility the patient may distribute the drugs to others.

- Be aware of the possibility of an illicit market for the drug.
- Keep complete and accurate medical records that reflect the examination, evaluation and treatment of the patient, as well as the diagnosis and purpose for which the controlled substance is used.
- Do not use Schedule II drugs except as provided in Rule 4731-11-03, OAC.
- Do not use a Schedule II controlled stimulant for weight reduction or weight control.
- Follow provisions of Rule 4731-11-04, OAC when considering prescribing Schedule III or IV controlled substances for weight reduction.
- Know that the use of drugs to enhance athletic ability is prohibited. ■

Anand G. Garg, MD, Youngstown, is a member of the Ohio State Medical Board; Joan Wehrle is the OSMB's public inquiries officer.

Americans With Disabilities Act – one year later

It has been a little more than one year since the first provisions of the Americans With Disabilities Act (ADA) became effective. The public accommodations provisions of the law became effective on July 26, 1992. On the same day, employers with 25 or more employees had to comply, and on July 26, 1994, employers with 15 or more employees will have to comply with the employment provisions.

PRACTICE PROVISIONS

The public accommodations provisions affected almost all physician practices. By now physicians have removed architectural and communications barriers when readily achievable. Additionally, auxiliary aids and services have been provided, so long as they do not fundamentally alter the physician patient relationship. The auxiliary aids and services requirement is the provision that has had the most impact on physician practices. Most frequently at issue was the necessity of providing qualified interpreters for deaf or hearing impaired patients. In most cases, it was necessary for the physician to provide an interpreter at the physician's expense. However, in some cases doctors and patients agreed that no interpreter was required.

PROVISIONS AFFECTING LICENSURE AND PRIVILEGES

While physicians in Ohio are rarely employed by non-physician owned entities, the application of the ADA to physician-hospital relationships is an issue of concern to many doctors. Employers must extend the non-discrimination provisions to all employees. However, physician members of the hospital medical staff are not employees. Does this mean the hospital is not required to apply the non-discrimination provisions to doctors? This question is yet to be answered. Because most non-discrimination laws apply to employees, it is questionable whether hospitals are required to deal with physician medical staff members in the same ways they treat employees.

Finally, there is some case law in other states holding that licensing entities may make inquiries that are

discriminatory in nature. For example, while an employer may not ask specific questions about prior alcohol or drug abuse history, the state medical board may do so

when considering an applicant for licensure or relicensure. The courts have held that state licensing entities have a right to this information because their goal is public

protection and access to this information may assist in furthering that goal. For more information contact the OSMA Department of Legal Services. ■

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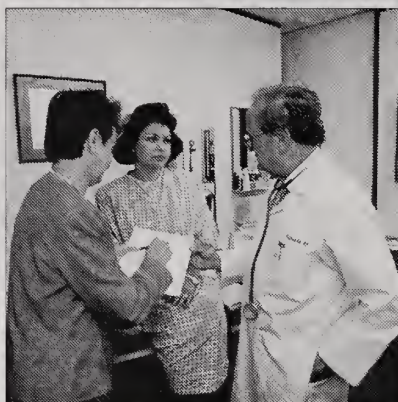
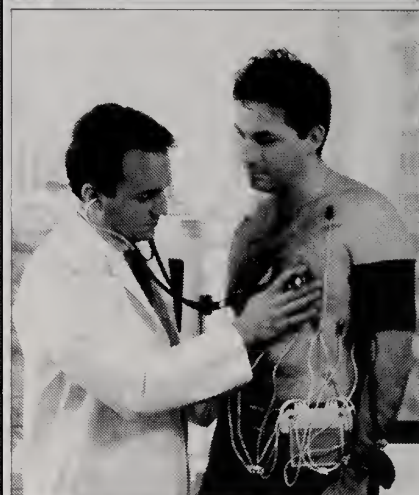
"After years of study, I honestly believed that I was ready to go into practice. I thought that knowledge and experience in medicine was all that I'd need to be a success out there. But, no one ever mentioned that I'd have to be an expert at insurance, law and collections...I'm a doctor, with a substantial amount of money and time invested in being the best that I can be. It didn't take long for me to realize that the time spent in managing my business was time taken away from the really important things in life; my patients, my family, and myself."

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PICO's New CEO Speaks Out

John Albers, MD, the new CEO of the Physicians Insurance Company of Ohio, speaks frankly about his company and its past — and future — ties with the OSMA.

Q. Your numerous professional accomplishments and active involvement in organized medicine at the local, state and national level well qualifies you for your new role as CEO of PICO. But which of your attributes do you think uniquely suits you for this new position?

A. I think that I have shown leadership in all of my involvements, as well as an ability to provide direction, focus in on a problem and get it solved. My communication skills also helps qualify me for this position.



Q. Have you set any goals or future direction for the company?

A. My primary goal is to make PICO a very good malpractice insurance company. By that, I mean continue to offer our policyholders the same high-quality service we have always provided and, at the same time, make the company profitable to shareholders.

I have some long-range goals as well, and though I won't go into specifics here, you should see PICO become leaner and more efficient in the future. We will also become more visible to policyholders and more aggressive in what has become a highly competitive marketplace.

Q. Will policyholders notice any change in the way that PICO will be run now that the OSMA no longer owns shares in the company?

A. I would reassure our policyholders that we are a financially stable company. There shouldn't be any fear that we won't be around to take policies or pay claims, now or in the future.

At PICO, we were pleased with the purchase of OSMA's Class B shares. I think that situation came to a satisfactory conclusion. Our goal now is to work closely with the OSMA, so I don't think policyholders will notice any real differences in the operation of PICO, even though OSMA no longer owns shares.

Q. What effect will Quaker Holdings — the company that recently invested \$5 million in PICO — have on operations?

A. Certainly the capital infusion will give the company a financial boost. Then, the seats that Quaker Holdings will occupy on the Board of Directors will provide us with more experience in the

business and management aspects of running PICO. We expect them to provide us with a new perspective.

However, PICO still has a physician-majority board, and as a physician who is chair of that board, I think it's also beneficial that our company can look at the business from the physician's viewpoint as well.

Q. Some PICO policyholders have noticed an increase — and some a substantial increase — in PICO rates. What has caused this, and how many policyholders have been affected?

A. The rate increase has affected some policyholders more than others, depending on what class they're in. It was a generalized increase, recommended by our actuarial consultants, to cover the amounts of projected future claims. I want to make it clear this was not done to recoup any loss of premiums or reserves that PICO has experienced in the past. The rate increase was made to provide for the future, not to recover from the past.

Q. What makes PICO unique in the industry?

A. First, we offer an unconditional consent to settle claims. I don't know anyone else in the business who offers that. Second, our Team PICO provides policyholders with the best back-up in case of a malpractice suit, providing both psychological and legal support. Third, we offer outstanding risk-management programs, and we'll be intensifying our efforts in this area in the future. We offer, for example, in-office audits and mock trials to help those policyholders who need to testify, either as expert witnesses or in their own behalf. Finally, we can provide excellent testimonials from policyholders we've defended in malpractice trials.

Q. Where do you see PICO five or 10 years from now?

A. I want to see PICO as a strong force in the industry, responsive to policyholders and profitable to shareholders. Right now, we're keeping abreast of health-care reform and how the different proposals will affect this business. We intend to adapt and be as flexible as necessary.

Q. Any final comments you wish to make?

A. Our subsidiary companies continue to be profitable, and we hope to offer a new product, a critical-illness policy, through American Physicians Life soon — the first company to make such a plan available.

PICO will also begin to develop a different focus, a definite direction. We will no longer be out there indiscriminately writing policies. We will find our niche in the marketplace and write malpractice policies appropriately.

COLA provides alternative to federal inspection

In Brief: The OSMA encourages its members to seek clinical lab accreditation through COLA. Here's why and how to enroll.

Physicians' offices do have a choice when it comes to complying with the Clinical Laboratories Improvement Amendments (CLIA) '88 regulations. They may choose either federal inspection or private accreditation.

The OSMA House of Delegates adopted a resolution at its Annual Meeting in May encouraging all physicians to seek clinical laboratory accreditation through the Commission on Office Laboratory Accreditation (COLA) rather than federal certification.

COLA is the only private accreditation program. The program, sponsored by the American Academy of Family Physicians, the American Medical Association, the American Society of Internal Medicine and the College of American Pathologists, is a voluntary, non-profit accreditation and education program for physician office labs.

COLA MAY BE MORE COST-EFFECTIVE

Physicians who enroll in the COLA program will not be billed by HCFA for an inspection or placed on the list of facilities to be inspected by state and federal surveyors.

The COLA program may be more cost-effective for some physicians since HCFA's fees are based on the volume of testing and number of

COLA's program may be more cost-effective for some physicians.

specialties of testing, whereas COLA's fees are based on the number of physicians using the laboratory and the number of specialty categories tested.

However, COLA is not a proficiency testing program. Physicians who participate in either the federal program or COLA need to purchase a proficiency testing package from an approved testing program.

HCFA will not issue a biennial compliance fee to any laboratory that indicated on their HCFA Form 116 that they will seek a certification of accreditation nor will the physicians' offices be subject to CLIA inspections. Laboratories that are accredited by COLA are "deemed" to meet federal CLIA '88 standards. If you did not check the

appropriate box for "certification of accreditation" on your HCFA 116 form you can amend your form by contacting the HCFA office.

Whether or not you are enrolled in a private accreditation program, however, you must register with HCFA by completing the HCFA 109 survey form and paying a registration fee.

SERVICES COLA PROVIDES

COLA provides its physicians' offices with a comprehensive self-survey to help them prepare for the COLA on-site survey. Once completed, COLA will evaluate the self-survey and provide physicians

with a report of deficiencies and ways to correct them.

The COLA surveyors, who are trained and familiar with the nature of a physician's office, will assist laboratory staff and offer suggestions and technical advice to improve laboratory performance.

Another plus, COLA-accredited laboratories will not be subject to routine biennial federal inspections or the cost of the federal inspection.

Any questions about the COLA program can be directed to Tammy Zinsmeister, COLA coordinator of Government Relations, at (206) 343-1456. ■

Differences in HCFA/COLA Lab Inspections

HCFA:

- Labs on list of facilities to be inspected biennially by federal, state surveyors.
- Fee for federal inspection.
- Fees based on volume of testing and number of specialty categories tested.

COLA:

- Self-survey to prepare for on-site survey.
- No routine biennial federal inspection.
- No fee for a federal inspection.
- Fees based on number of physicians using laboratory and specialty categories tested.

Medicare won't reopen enrollment

The Health Care Financing Administration (HCFA) has rejected a request by Medicare to reopen the 1993 Medicare participation enrollment period for Ohio physicians.

The request was made by William P. Sawyer, MD, co-chair of Medicare's Ohio Carrier Advisory Committee, on behalf of several Ohio physicians who were unaware of the imminent passage of House Bill 478, the health-care reform bill. That bill, which was signed into law in January, prohibited physicians from collecting balances from certain Medicare beneficiaries.

In its letter, HCFA stated that, according to the Social Security Act, the decision to participate in the

Medicare program must be made before the beginning of the year.

The only physicians exempt from this law are those new to practice at the time the enrollment period ends.

Many Ohio physicians, however, were informed about the prohibition on balance billing provision in HB 478 – primarily OSMA members who were provided with information about the provision in December. In fact, the 1993 participation enrollment rate increased by 33.7% over the 1992 rate.

For those who wish to participate in the Medicare program, the next enrollment will begin sometime in November. ■

Medicaid hard copy claims delayed

The bad news is hard copy claims filed with Medicaid are taking up to three months to process. The good news is, if the claims are "clean," you'll receive interest on the amount.

The Ohio Department of Human Services (ODHS) is required by law to pay interest on clean claims delayed in processing – but the message ODHS wants to give physicians is that electronic claims have experienced no delays, and processing them takes only 7-14 days.

Since January, processing hard copy claims have taken as many as 120 days, ODHS told the OSMA Ombudsman staff. Recently, the

ODHS staff has reduced the backlog, but physicians can still expect to wait 60-90 days before seeing payment. That's why they encourage physicians to submit their Medicaid claims electronically.

If you have questions, contact the Ohio Department of Human Services, 1-(800) 686-1516 or 1-(800) 686-1564. ■

If you have questions about any story in the Third-Party Update section, contact the OSMA Ombudsman staff at 1-(800) 766-OSMA.

Cities, counties grapple with licensing tattoo parlors

Tattoo parlors around the state are causing a stir. Besides evoking the usual stereotypes, questions are being raised about the sanitary conditions of the businesses.

Even though tattoo artists use needles to pierce a client's skin, and autoclaves to sterilize their equipment, the Ohio State Medical Board does not regulate or license such businesses, nor does it plan to.

"It would help to have some state guidelines to go by," says a health commissioner.

"We have discussed cosmetic tattooing, such as permanent eye-lining," says Lauren Lubow, a board spokesperson, "but the board never took action on it. We don't have any position paper on it. It really has been left up to city health departments."

Similarly, the Ohio Department of Health doesn't oversee tattoo parlors, nor does the Ohio Board of Cosmetology (which does oversee barbers and hairstylists), leaving the development of regulations and inspections up to the city or county that feels it needs to control the potential health risks posed by tattoo parlors.

One such principality, Medina County, has recently begun looking into regulating tattoo parlors since the county is home to three such businesses.

Though an event at one parlor garnered some local headlines, it was not the reason the county decided to regulate the businesses, says Medina County Health Commissioner David Baldwin.

"An operator in Brunswick found medical waste behind his business, and he was concerned, of course," says Baldwin, "but it probably came from a physician's office" that previously leased the building.

The county, says Baldwin, is simply interested in ensuring that the businesses comply with basic sanitary standards.

"It would help to have some state guidelines to go by," concedes

Baldwin, "otherwise each political subdivision can come up with who knows how many regulations."

At press time, the county's Health Board was to meet to decide how to inspect tattoo parlors and

issue permits. "We'll make sure (parlor owners) are using sterile equipment, and if they're reusing equipment that they're auto-claving," says Baldwin.

"We'll make sure that they're

using antibacterial ointment and that the operators are clean and disease-free, and that they're tested for tuberculosis," he says, adding that the latter is more for the operators' safety than their customers'. ■




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Hospital accepting applications from chiropractors

A hospital in central Ohio is the first in the area to announce that it is accepting applications for staff privileges from area chiropractors.

Columbus Community Hospital recently began extending full hos-

pital privileges to chiropractors, becoming the 41st hospital nationwide to do so. Chiropractors who qualify will not only have staff and voting privileges but will also have the right to co-treat patients who

have been admitted to the hospital and to use all ancillary services (state law prohibits chiropractors from admitting patients).

According to Bobby Meadows, Columbus Community's CEO and

president, offering privileges to chiropractors will only enhance patient services. "Having chiropractors on staff only makes the treatment options for patients richer," he says.

"This complements our current treatment options for patients and encourages continuity of care for those patients who have been under a chiropractor and wish to continue their treatment during hospital stays."

Central Ohio chiropractors are also pleased that their services are given validity by being offered in a hospital setting.

"We're pleased that...the medical staff at Columbus Community Hospital has taken this historical step," says Kris Keller, DC, president of the Central Ohio Chiropractic Association.

Offering chiropractic services in the hospital setting may also prove cost-effective, says Dr. Keller, who notes, "Hospitals in other areas of the country that have chiropractors on staff have seen patients get better faster and at a lower cost." ■

Breast of chicken



3-oz., cooked serving of chicken breast

Best of pork



3-oz., cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.^{1,2*}

Compare pork with chicken^{1,2*}

| | Calories | Total Fat | Saturated Fatty Acids | Cholesterol |
|---|----------|-----------|-----------------------|-------------|
| Chicken Breast, skinless | 140 | 3.0 g | 0.9 g | 72 mg |
| Pork Tenderloin, trimmed | 139 | 4.1 g | 1.4 g | 67 mg |
| Pork Top Loin Roast (boneless), trimmed | 165 | 6.1 g | 2.2 g | 66 mg |
| Center Loin Chop, trimmed | 172 | 6.9 g | 2.5 g | 70 mg |
| Chicken Thigh, skinless | 178 | 9.2 g | 2.6 g | 81 mg |

*Table refers to 3-oz., cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.¹ According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.¹

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz., cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.

2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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Licking Memorial HMO gaining national attention

As one of the first hospitals in the country to create its own in-house managed care plan, Licking Memorial Hospital is fast becoming a model for other health-care facilities nationwide.

Conceived of six years ago, the Licking Memorial Hospital Health Plan represents a joint effort between hospital and local doctors. And the results have been admirable: The plan boasts 20,000 enrollees and administrative costs of less than half that of competing HMOs.

So admirable, in fact, that the plan has received national interest. Pattye Whisman, MD, a Newark family practitioner and chair of the plan's Board of Trustees, says that representatives from 50-60 communities have come from all over the country to see the plan in action.

"A lot of folks don't have anything set up," Dr. Whisman says, explaining all the interest. "You know, what are they going to do?"

What visitors get is an in-depth look at how the plan was developed and why it works.

"We first started this plan because we had other HMOs coming to town," says Dr. Whisman. "It was our first experience with them and it scared us. They were taking our patients...patients were going to Columbus for treatment."

Instead of sitting idly by, local physicians and hospital officials joined forces and came up with the plan, which is capitated. "We're the parents of this plan," says Dr. Whisman, "but we have a number of other people involved in it." For instance, she notes the governing board is made up of physicians, hospital administrators and local consumers.

Also, says Dr. Whisman, the group's numerous committees represent a variety of health-care professionals, such as the pharmacy committee, which involves many pharmacists. "We're trying to manage care," says Dr. Whisman, "so everybody participates in this."

For the most part, says Dr. Whisman, local physicians have been accepting of the plan. "It's been difficult for some doctors to accept it. You can look at it as helping you or you can look at it as interference," she says. "It's a lot better than other plans out there because at least physicians have a say in things."

From a medical standpoint, the plan has been helpful because it allows physicians to more carefully monitor their patient, says Dr. Whisman. For example, regular computer-generated letters are sent to patients reminding them that they're due for a particular procedure, such as a mammogram. The system is also able to tell physicians whether or not their patients are filling their prescriptions. "It really helps," says Dr.

Whisman, "because with the input I get from pharmacies and the computer reviews, it helps track patient care."

Enrollees, too, seem to have taken to the plan. "It's difficult at first to under-

stand that you can't run to all sorts of specialists," says Dr. Whisman, but patients understand the bottom line – that concentrating on preventive care saves money.

Dr. Whisman says that another advantage of the plan is that administrators constantly negotiate for the best care at the best prices. For example, "We have a capitated plan with Children's Hospital and Riverside/Grant (in Columbus)," says Dr. Whisman. "We pay them so much per member per month to care for all children under 14 who need tertiary care." By negotiating, she says, "then we have a handle on our costs." The same thing applies to other treatments the hospital isn't able to provide, such as bone marrow transplants. "We'll cover it," says Dr. Whisman, "but we'll negotiate the fee. We want to know what it's going to cost."

As for the plan's future, Dr. Whisman says the health plan would like to take over managing Medicaid and Medicare, which

spend about 25% of their budgets on administrative costs, compared to the health plan's 6.5%.

"We'd like to have all that money for the county. Think how much more care we could provide," by cutting administrative fat, she says.

Furthermore, "We think we're set up to do it...We don't think the system needs more money; we think it needs to be better managed."

With all the talk that the Clinton administration's health reform plan will be based on managed care, could Licking Memorial's plan serve as a model?

"Sure," says Dr. Whisman, "but it would still need to be on a small scale, be it a county or city. How can the government possibly come

up with one plan for the entire country? I think it has to be done as small projects.

"Also," she continues, "I think we need to get rid of some of these federally and state-mandated rules and let the different health plans try out their ideas for six months or a year and see how they do. Right now there's just too many rules." ■



Dr. Whisman

"We don't think the system needs more money; we think it needs to be better managed."

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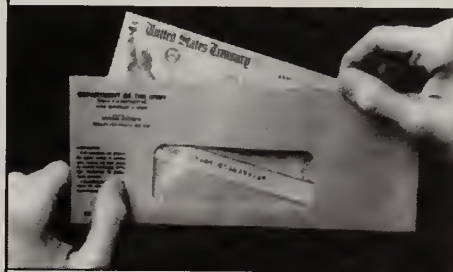
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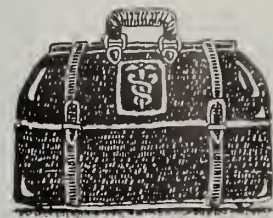
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OMAR ELAZAR, MD, Canton; Facultad de Medicina de la Universidad de Santo Domingo, Ciudad Trujillo, Dominican Republic, 1951; age 65; died June 1, 1993; member OSMA.

MORRIS B. GUTHRIE, MD, North Port, FL; Ohio State University College of Medicine, 1935;

age 90; died June 3, 1993; member OSMA and AMA.

M.W. LIVINGSTON, MD, Sunbury; University of Wisconsin Medical School, Madison, WI, 1933; age 86; died April 28, 1993; member OSMA and AMA.

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OHIO *Medicine*

News for Members of the Ohio State Medical Association

Workers' Comp bill passes

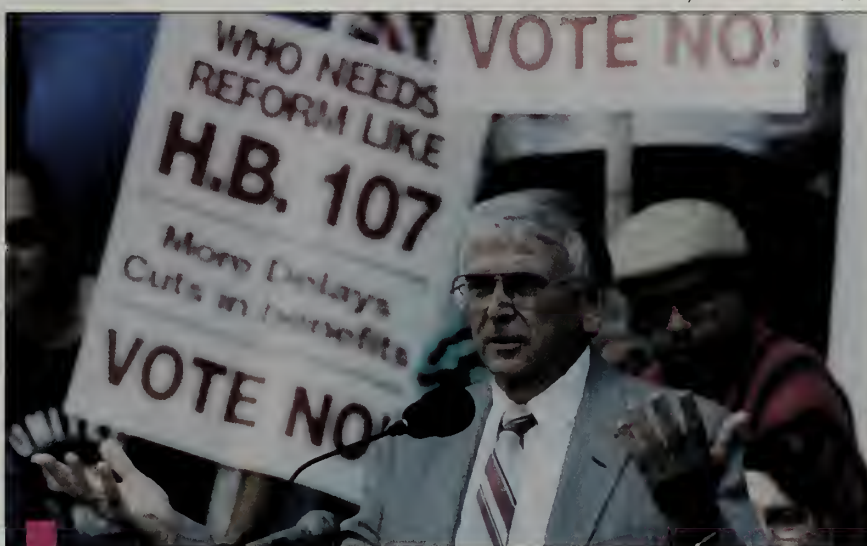
Managed care part of reform bill

In Brief: The OSMA may not have been able to maintain freedom of choice for Workers' Comp patients, but at least physicians will have some input into how the bureau's new managed-care system will run.

With the passage last month of House Bill 107, the Workers' Compensation reform bill, the state for the first time has sanctioned managed care for the state's Workers' Comp system.

"The business community sold managed care as the solution to the system's rising health-care costs," advises John Van Doorn, director of OSMA's Department of Legislation.

He predicts that by this time next year, Ohio physicians can expect the managed-care component, authorized by HB 107, to be implemented in the Workers' Comp system. Meanwhile, managed care has already made an appearance in Ohio's Medicaid program. The budget bill, which passed this



John Hodges, president of the Ohio AFL-CIO, speaks at a Workers' Compensation rally, held recently on the steps of the Statehouse.

summer, has established managed-care pilot programs in several more counties in an effort to curb spiraling Medicaid costs.

Recognizing that a managed care network in the Workers' Comp

system was probably inevitable – "Gov. Voinovich joined the business community in pressing for managed care," says Van Doorn – the

See **WORKERS'** page 3

Statewide Medicare fee schedule HCFA waiting on letters

Don't forget. You have until Sept. 13 to write the Health Care

Financing Administration regarding implementation of a statewide fee schedule for Medicare.

HCFA announced that if it receives what it considers to be enough letters of support from Ohio physicians, it will convert the state to a single fee schedule effective Jan. 1,

1994.

Ohio now has 15 pricing regions for Medicare, based loosely on cost-of-living differences between urban and rural areas.

The OSMA, which is in favor of a statewide fee schedule as the result of a resolution approved at the 1992 OSMA Annual Meeting, alerted Ohio physicians to the need for letters in the August issue of *OHIO Medicine*. In addition, Walt Reiling, Jr., MD, president of the OSMA, has written HCFA once again expressing physician support for the change.

All correspondence should be addressed to: HCFA, Attention: BPD-770-P, P.O. Box 26688, Baltimore, MD 21207. HCFA has requested that physicians send three copies with their original letter. All correspondence must be received no later than Sept. 13. ■

OSMA to alert docs via fax

The OSMA is establishing a fax newsletter for members. Called Member Alert, this one- to two-page newsletter will be faxed to participating members on an as-needed basis – probably no more than once a month. The newsletter will be ready to use by October 1st.

Member Alert will contain the latest legislative and reimbursement news, as well as other information of interest to physicians. It will augment the information contained in *OHIO Medicine*.

To receive Member Alert, complete the application form elsewhere in this issue and fax it back to the OSMA. Call the Department of Communications at 1(800) 766-OSMA if you have questions. ■

Inside

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■ **GROUP PRACTICE:** Is joining a group practice for you? *OHIO Medicine* looks at both sides of the issue. 10



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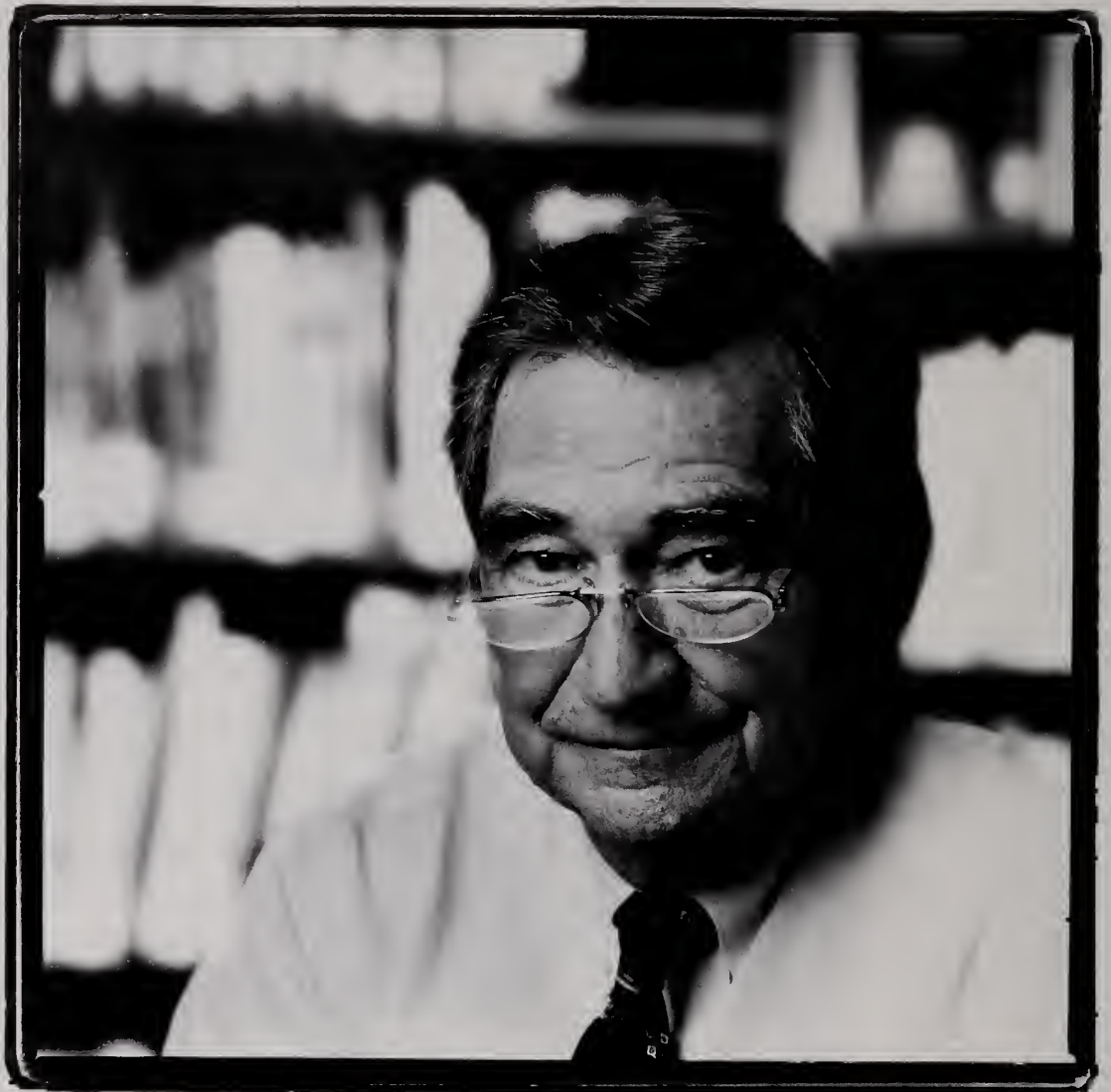
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OSMA, along with representatives from labor and other provider groups, endorsed a provision that would allow any provider, willing to abide by the terms of a managed-care network, to enroll in the BWC system.

"We wanted to give patients the freedom to choose their own physicians," says Claire Wolfe, MD, OSMA's president-elect – and throughout the bill's passage through the Statehouse, state legislators seemed in favor of the OSMA provision, says Van Doorn. "Then, at the 11th hour, the business community made a strong push to eliminate the provision," he says. The bill's final version emerged from the Statehouse without the "any willing provider" clause.

PHYSICIANS TO HAVE INPUT

Despite that disappointment, the OSMA did emerge with a victory.

"When we were presented with the Workers' Comp reform bill, we had basically two concerns," says Dr. Wolfe. "We wanted any willing provider able to participate in the program, but we also wanted physicians to have more input into the BWC decision-making process."

The BWC had already implemented some managed care elements this year, such as prior authorizations and treatment limitations, without soliciting physician input.

Then, this spring, the BWC, in

Health Partnership Program

The BWC will implement its new "Health Partnership Program" by July 1, 1994. Here are details of this program:

- The BWC will contract with an "external vendor" to provide "medical management and cost-containment services" to injured workers.
- With BWC board approval, freedom of choice of health-care providers may be limited by requiring BWC patients to co-pay when they select providers who are not part of the program's network of providers.
- Physicians outside Ohio, or in areas of the state where there are no network physicians will be permitted to treat BWC pa-

tients. However, these physicians will be paid according to a BWC managed-care fee schedule, and they may not balance bill the patient, employer or the BWC.

Quality Health Plan

By January 1, 1995, the BWC will implement its "Quality Health Plan," which will allow employers or groups of employers to form their own health plans. Here are the elements of this program:

- A Health Care Quality Advisory Council will be formed to develop specific standards and qualifications for these health plans. This is where physicians will have some input into BWC's managed care process. Five providers – including a medical and an

osteopathic physician – will be included on this council. Their recommendations to the BWC board will be made by July 1, 1994.

- After receiving the Council's recommendations, the board will develop rules on the standards for health-care plans. Before promulgating these rules, however, the BWC board will receive additional input on its proposed standards from a Health Care Advisory Committee. This committee will be composed entirely of health-care providers, including a physician.
- Any plan that meets the board's final, approved standards will be eligible to provide medical management services for employers. ■

what was a surprise move for most physicians, lowered its UCR levels, in effect reducing reimbursement to physicians, again without soliciting provider feedback. That not only prompted a sharp rebuke from the OSMA, in the form of a letter to the BWC, but encouraged the association to seek amendments in the Workers' Comp bill that would assure more physician input into BWC decisions.

"Although no physician serves

on the BWC board where decisions are made, we did receive appointments on two committees that will advise the bureau on managed care issues," says Dr. Wolfe.

The OSMA also successfully preserved the right to appeal all BWC rules to a legislative body – enabling the association to block unwarranted rules that intrude on the practice of medicine in the BWC system.

Just how Ohio physicians will

view the association's wins and losses, and the new managed-care, Workers' Comp system, is difficult to say.

"As Senate President Stanley Aronoff put it, this is a complex issue that's difficult to understand," says Dr. Wolfe. "Who knows, yet, how it's going to work?"

Or, for that matter, how it will be accepted by OSMA members. ■

BWC wants proof that fees are too low

The CEO of Ohio's Workers' Compensation program has responded to OSMA's objection to its reduction in provider fees and is asking Ohio physicians for proof that its fees are too low.

As reported in the June issue of *OHIO Medicine*, President-elect Claire V. Wolfe, MD, sent a letter to Wes Trimble, CEO/Administrator of the Ohio Bureau of Workers' Compensation (BWC) expressing OSMA's opposition to BWC's April 1, 1993 implementation of a revised fee schedule for reimbursement of physician services.

Trimble responded in a letter by stating "if a particular reimbursement is identified as being out of line with payment levels currently accepted from other insurer/payers, we will be happy to look at individual procedure codes and re-

evaluate these payment levels."

Trimble went on to say, "If your member physicians identify an individual procedure code for which the fee maximum is disproportionate to the payment levels of other insurer/payers, we will be happy to review the matter."

Physicians who have identified a particular reimbursement as being out of line with payment levels currently paid by other insurers should provide the OSMA Ombudsman Staff with such examples. Please include the CPT code, current BWC reimbursement level, amount currently being paid by other carrier, and identification of other carrier. This information will be compiled and a follow-up letter will be sent to Trimble. ■

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KNOWLEDGEABLE

Certificate-of-need law to expire in November

The certificate-of-need (CON) law, which requires health-care facilities to obtain state approval prior to certain capital expenditures and equipment purchases, expires in November, but a bill is pending in the Ohio Legislature that would continue the program.

Whether or not the program would remain in its present format, however, is the subject under study by an advisory committee, chaired by Sen. Grace Drake (R-Solon) and including among its members John A. Devany, MD, Toledo, an OSMA past president who is representing the interests of OSMA.

"The committee will certainly recommend that the CON law be

extended," says Cynthia Snyder, associate director of OSMA's Department of

Legislation. However, there has been some discussion among committee members on major changes that may also be recommended.

"There is talk of leveling the



Sen. Drake

playing field," says Snyder, which means that certain committee members want to see the CON law made applicable to all providers. Presently, there is a perception that physicians' offices have a blanket exemption under the current CON law, but Snyder says that's not true. "There are certain exemptions for physicians' offices, but there is not a blanket exemption," she says. Just how physicians' offices will be ultimately affected by the recommended changes has yet to be determined.

OHIO Medicine will keep you updated on developments in this area as they occur. ■

Managed care and the movies

An eleventh-hour addition to the state's Workers' Comp bill ensured that Kieran Culkin, the 10-year-old brother of "Home Alone" star Macaulay Culkin, could work in Ohio.

Once MGM learned that Ohio's child labor laws don't allow anyone younger than 14 to work, it said it may have to look elsewhere for its film's setting. That meant a potential loss to the state of \$20 million.

Eventually, a provision was included in the Workers' Comp bill allowing the star to work. However a two-year time limit was placed on the child-actor exemption. ■

Ohio's Human Services may privatize Medicaid

By October 1, the Ohio Department of Human Services is expected to issue a proposal that will seek state control of the Medicaid program – in effect, privatizing the \$10 billion health-care fund that provides coverage to about 1.4 million Ohioans who live below the poverty level.

How will ODHS Director Arnold Tompkins propose to run the state-controlled program? Through managed competition, the same way that "TennCare," Tennessee's "blueprint" of a privatized Medicaid system, is likely to be run.

TENNCARE A GOOD EXAMPLE

TennCare, which was expected to receive federal waivers from the Clinton administration late last month, features a number of managed-care elements, including comprehensive benefits for those presently without coverage, an emphasis on preventive care and a closed network of providers.

With the TennCare program, the Tennessee state government hopes to stretch its \$2.8 billion federal and state Medicaid monies (along with additional federal money the state receives for other health-care programs) to cover the one million people in Tennessee on Medicaid – plus an additional 500,000

others who aren't presently insured.

PROVIDERS TO COMPETE

The problem of spiraling Medicaid costs – and the increasing

Privatization is expected to cover about one-third of Ohio's 1.2 million uninsured.

number of uninsureds not covered by Medicaid – is what is prompting state officials to look at its Medicaid system as well.

According to news reports, Tompkins will probably propose that insurers and health-care providers compete for state contracts to administer the Medicaid program. Privatization of the system is expected to cover, in addition to the state's present Medicaid patients, about one-third of Ohio's 1.2 million uninsured.

Even if the federal government granted Ohio a waiver – which wouldn't happen until February or March at the earliest – the pro-

gram would still take two or three years to put into place.

PLAN SEEMS LIKELY

However, at this point, Medicaid seems likely to be privatized in Ohio in the future. The passage of the state budget bill this summer has already launched Medicaid managed-care pilot programs in several counties, while also this

summer, members of the Ohio Health Care Board paid close attention when consultants from a private foundation told them how they helped other states develop proposals to free them from federal Medicaid oversight.

Ohio physicians may be wise, then, to keep an eye on Tennessee. As its Medicaid system goes – so might Ohio's. OHIO Medicine will keep you posted. ■

Sen. Hobson tackles Medicaid issue

U.S. Rep. David L. Hobson (R-Springfield) has introduced legislation that would permit states to revise their Medicaid programs to extend coverage to more poor people, as well as hold down health-care costs.

The Medicaid Health Allowance Act would allow privatizing of state Medicaid programs so that states could redirect Medicaid money into managed-care systems.

"Allowing states to privatize Medicaid lets them use innovative solutions to expand access to care, and cover those people in the gap," says Hobson in news reports on the subject. "It would allow us to reach out to those

people who are most desperately in need, and offer the access to quality care."

Ohio is one of 15 states considering a privatized Medicaid system to control costs. Without a change in federal law, the government would need to give these states waivers to try their new programs. President Clinton is expected to grant such a waiver to Tennessee soon.

Rep. Hobson's proposal uses as a model the Dayton area health plan, a pilot managed care program that provides coverage to about 29,000 poor residents.

OHIO Medicine will keep you posted on further developments. ■

Nurses, physicians meet over expanded scope of practice

As health-care reform approaches, with its focus on primary care, Ohio nurses continue to call for an expanded scope of practice. In House Bill 183, the Medicaid Reform bill, nurses are seeking greater prescribing powers than those they received under House Bill 478, the health-care reform bill that established several pilot programs around the state that allow nurses to prescribe medicines under certain restrictions.

Meanwhile, members of the OSMA Nurse Liaison Committee, chaired by Edmund Casey, MD, Cincinnati, have been meeting over the summer with representatives of the Ohio Nurses Association to determine whether or not there is room for compromise.

"They are looking at two key issues with the nurses," says Robert Clinger, director of OSMA's Department of Medical Society Relations. One of these issues is the nurses' desire for legal recognition of the nurse-credentialing process. Specifically, they want recognition

of the Advance Practice Nurse and at this point, says Clinger, physicians are comfortable with the idea of statutory recognition of APNs.

Nurse-prescribing, however, is a different matter. "Committee members are willing to discuss protocol arrangements where a nurse could prescribe medication under a physician's supervision," says Clinger.

But nurse representatives say they are unwilling to accept the idea of "physician supervision." Instead, they say, they want to work

in a collaborative arrangement with physicians. They also want to continue to expand their prescribing powers as quickly as possible.

"The committee has taken the position that we need to collect data from the pilot programs first, and see how those are working out before we expand nurse-prescribing any further," says Clinger.

The committee expects to continue meeting with the nurses throughout the fall. ■

Immunizations challenged

House Bill 367, sponsored by Rep. Ronald Gerberry (D-Canfield) has raised controversial views over the subject of childhood immunizations. Its language states that children do not have to receive an immunization booster before they are admitted to the seventh grade.

The bill has stemmed from parents and others upset over disabilities they say were caused children by either a vaccine or a booster shot.

The OSMA, as well as the Ohio Department of Health and the Ohio Chapter of the American Academy of Pediatrics, have sent representatives to testify that public health experts agree on the need for children to receive initial immunizations and the pre-seventh-grade boosters. Evidence on the subject clearly indicates that the health hazards from lack of immunizations significantly outweigh the risk of an adverse reaction to the immunizations themselves. ■

Bill would expand PAs' duties

House Bill 183, the Medicaid reform bill, would expand the scope of practice for physicians' assistants as well as nurses. PAs have sought the right to be "institutionally employable," so that they might be hired by hospitals, as well as by physicians. They are also seeking prescribing privi-

leges, under physician supervision, and autonomy for their advisory committee that is currently under the auspices of the State Medical Board.

House Bill 183 will be considered by the Senate Health and Human Services Committee when legislators return this fall. ■

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Physicians should involve patients in health discussions

Later this month, when the federal Legislature reconvenes, President Clinton may finally release his plans for health-care reform. Of course, the minute he issues his report, both the AMA and OSMA will provide you with immediate feedback.

Until then, you may want to involve your patients in discussions about health-care reform – if you haven't already.

The AMA has compiled a list of 10 questions for patients – to help them decide if the Clinton proposal for health reform is good for them and their families. Post the list in your waiting room, or take a moment to discuss a couple of points with your patients the next time they come for a visit.

Ten questions to ask yourself

about the Clinton health reform proposal:

1. Will I still be able to see my own doctor? Will I have to pay extra? And will my doctor and I be free to decide how to treat my illness?
2. I have a group insurance policy through my employer. Will that change? Will my premiums, deductibles and co-payments go up?
3. Will I be able to choose my own type of health-insurance? And can I buy extra insurance if I want it?
4. Will anything be done to reduce and simplify all the insurance forms I have to fill out?
5. What happens if I change jobs, get sick or am injured? Will I risk losing health insurance coverage?
6. What if someone in my family has a pre-existing health condition? Will they be covered?
7. Will the quality of care my family receives be maintained under a new system?
8. I'm retired and on a fixed income. Will my Medicare coverage be affected?
9. Will costs be controlled in a way that doesn't interfere with my medical care?
10. Will everybody in America have health insurance? And, if so, how will we pay for this?



Be ready to discuss these points with your patients – and to tell them they can be instrumental in affecting change if they don't like the answers they're hearing. All they need to do is contact their legislators – on both the national and state level – and let their representatives and senators know what they think of the health reform proposal. ■



OSMA Health Task Force Meets

Teresa Long, MD, top left, and Daniel Handel, MD, listen during the proceedings of a recent meeting of the OSMA's Task Force on Health-Care Reform. At right, J. Robert Navarre, MD, takes notes. The task force has been commissioned with developing a statewide health reform proposal.



State's only health-reform bill – so far

While the Ohio Health Care Board and the OSMA Task Force on Health-Care Reform continue to meet and discuss their respective proposals for health-care reform for the state, State Rep. Robert F. Hagan (D-Youngstown), the "father of UHIO," has already leaped out of the starting gate with House Bill 341.

HB 341 was introduced this spring and has already had several hearings before the House Health and Retirement Committee. The bill basically seeks to extend access to health care for all Ohioans, while at the same time control costs. Sound familiar? It should. In a number of ways, Rep. Hagan's bill sounds as though he were taking tips from President Clinton. For example, HB 341 would mandate an employer-employee tax to help pay for health-care costs – just the way that Clinton is expected to seek an employer-employee tax to ease the health-care budget. Rep. Hagan is in favor of a sin tax to help pay for the health care of those who are unemployed, but not on Medicaid or Medicare.

In Rep. Hagan's view, HB 341 provides universal health-care

coverage for everyone in the state, while spreading the costs and holding down large line items like Medicaid.

"It's difficult to say how this bill is perceived at the Statehouse, because legislators didn't have much chance to consider it before the break," says John Van Doorn, director of OSMA's Department of Legislation. "But I think legislators will hold off making a decision on it until they see what the federal government will do." Or the state's own Health Care Board, for that matter.

In the meantime, the Health Care Board and the OSMA Task Force continue to shape their own reform proposals, eager to add their voices to what is, at present anyway, an isolated look at the health-reform issue. ■



PRESIDENT'S PERSPECTIVES

OSMA leadership – Is it too old?

As promised in last month's column, I am continuing to address some of the issues and concerns raised by those members who wrote me via *OHIO Medicine's* "Hey Walt!" cards, supplied in the May issue.

Several young physicians felt the OSMA leadership was dominated by older physicians. The implication, I believe, is quite clear: Within the OSMA, young physicians have no place to express their views and no opportunity to help shape organization policy. As one stated, "We have effectively been locked out of leadership positions at a time our input is vitally needed, not only for ourselves, but for all of medicine."

This issue is not new, nor is it trivial. Your current leadership is keenly aware of the needs and concerns of our younger members. To address these concerns we need first to examine the facts and ask some questions. Is our leadership truly old? How do you define "old" in medical circles? Medicine, after all, is really not a "young profession" when you consider we have very few active members below age

30. In fact, the AMA tells us the median age of physicians in the U.S. is 45. Perhaps we can use that age as an admittedly rough dividing point between young and old. Further, how do we define OSMA leadership? For the purpose of this discussion, I have chosen to examine three separate elements of our leadership: 1) the OSMA House of Delegates, 2) the OSMA Council (elected officers included), and 3) Ohio's Delegation to the AMA.

1) OSMA House of Delegates (1993) age distribution

| | |
|-------------|-------------|
| 30-39 – 10% | 60-69 – 20% |
| 40-49 – 26% | 70+ – 6% |
| 50-59 – 38% | |

2) OSMA Council – average age

| |
|-------------------|
| 1993 – 48.8 years |
| 1992 – 50.8 years |

3) Ohio Delegates to AMA (elected 1993) – average age

| |
|----------------------------------|
| Delegates – 62.8 years* |
| Alternate Delegates – 52.8 years |

(* Nationally, the average of age of an AMA Delegate is 63 years.)

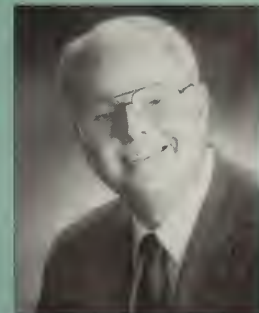
My interpretation of the above data suggests our Council would not be considered "old" by any criteria. Curiously, the average age of Council is considerably lower than the average age of our OSMA House of Delegates. Remember, Council members are elected by the House of Delegates. Perhaps the House of Delegates is indeed reflecting the concerns of our writers and is deliberately electing younger physicians.

Ohio's AMA Delegation, however, is almost (on average) 20 years older than our benchmark. Is this reason for concern? Is it perhaps appropriate? Please read on.

I really believe most OSMA members believe young physicians need and deserve leadership positions. The real question is whether it is or will happen in an evolutionary fashion or whether deliberate steps should be taken to cause change.

Term limitations and allocated or slotted positions for your physicians have been advocated. Currently, our Council has a six-year

Walter A. Reiling, Jr., MD



term limit lending some credence to this solution. Opponents of term limits, however, point out that it takes a number of years to learn the issues and to work within the system. To limit time of service, particularly at the AMA level, would probably severely cripple Ohio's influence within that organization.

In conclusion, please remember, it is you, the individual member, through our representative form of governance, who determined the composition of our leadership. If you have strong feelings on this issue, please make them known to your district delegation or an individual delegate. ■

OHIO Medicine

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OHIO Medicine, Editor
1500 Lake Shore Drive
Columbus, Ohio 43204-3824

(800) 766-OSMA



"Can't you just let her keep her tonsils until the health-care legislation is passed?"

SECOND OPINION

Increasing scopes of care: a bargain?

By Elizabeth S. Ruppert, MD

At last, health-care policy reform is at the top of the national policy agenda. Two major goals on that agenda are: 1) assuring access to health care for all Americans and 2) controlling costs.

In the coming months, as the health-care system is dissected and major changes occur, Americans need to be told that access to quality care is what they really want – and quality care has professional standards.

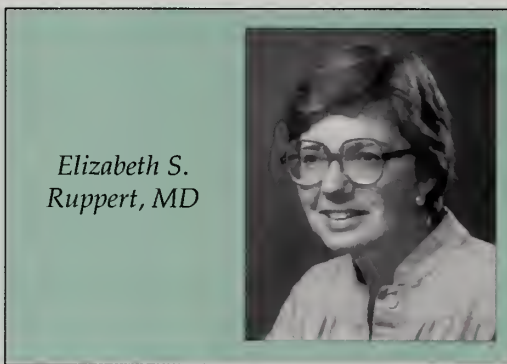
Not everyone agrees. *USA Today*, for example, had a cover page this spring that promoted physicians' aides and nurse-practitioners as independent providers of primary care. It was a solution, the article read, to providing accessible and affordable primary care. Closer to home, HB 478, which passed last year, authorizes a pilot project for nurses to practice independently in several Ohio cities. In the pilot project, nurses may prescribe drugs and therapeutic devices, and bill Medicaid. In a recent editorial in the *American Journal of Nursing*, the opening comments read: "You can

save money, improve quality and access to health care by putting primary care into the hands of nurses."

I am a pediatrician and member of the American Academy of Pediatrics (AAP). To meet the requirements of my profession, I had rigorous and lengthy training that began with an undergraduate college education, followed by four years of medical school, followed by successful passage of our medical licensing examination. Then came a minimum of three years of pediatric residency training and successful passage of a certifying board exam. Only the most capable and most committed are able to pass all of these hurdles! The lengthy and challenging educational program results in quality care, provided by pediatricians who understand the "why" of pathophysiologic mechanisms and the "how" of pharmacology.

The AAP has an official policy statement that clearly defines how a nurse-practitioner fits into the

practice of pediatrics. The AAP supports the concept that pediatric nurse-practitioners should be directed and supervised by physicians. Supervision implies the



Elizabeth S. Ruppert, MD

availability of a responsible physician, for the physician retains responsibility for such collaborative care. The AAP is opposed to the independent practice and/or billing by nurse-practitioners. Primary care of children should be delivered by licensed physician specialists.

American families need to be reminded that quality health care is what they want. A system of quality health care has educational and practice standards – not for the fun of it, but to protect the public and to

provide a uniformly high level of care. Falling below these standards could give American families a bargain of little value.

As our country and state chart a new course to promote universal access to health care, our citizens deserve quality in health care. To preserve quality, the payment to primary care physicians must be increased, and the imbalances corrected between subspecialist and generalist reimbursements. Medical schools need to improve their financial support and respect for primary care programs. Finally, the country must develop a national policy on the physician work force. If the best brains in our country can collaboratively work on all these issues, then American families may still have a chance to have universal access to a quality primary-care physician. ■

Elizabeth S. Ruppert, MD, Toledo, is a professor of pediatrics at the Medical College of Ohio.

ALLIANCE REPORT

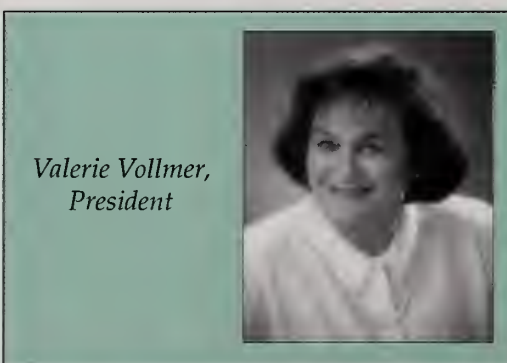
Good deeds deserve recognition

The fall days of crisp air, warm sunshine, brightly colored leaves, berries, apples, pumpkins, shorter days and crickets at night is just the beginning of actions and activities for members of the Alliance. Continuing with our regular work schedules, carpooling children to school and special activities, our members still find time to volunteer countless hours on various and numerous health projects in their communities.

It's essential that our communities are aware of these many efforts. Now, more than ever, it's important that the medical family be perceived as caring and involved. We must become our own public rela-

tions firm and make certain that our health education projects receive the fullest press coverage possible. We care, we're involved, and this must be made known to our neighbors.

The Ohio State Medical Association Alliance will assist our members with this goal by sponsoring a communication and media workshop, presented by Carol Mullinax, OSMA director of Communications, on October 19, 1993 at the Embassy Suites in Columbus. They will have the opportunity to tape a mock press/TV interview, receive pointers on



Valerie Vollmer, President

giving a speech and learn how to prepare news releases. Instructional guidelines on creating a county newsletter and who to contact regarding press and news coverage will also be addressed. Each member attending will receive a com-

munications workbook to aid them in their future efforts.

Let us take heed of a quote from Montaigne's Essays. "There is no pleasure to me without communication; there is not so much as a sprightly thought comes into my mind, but I grieve that I have no one to tell it to."

Information and project ideas on the domestic violence child abuse/neglect and elderly abuse will also be presented. This opportunity is open to all our members. Please contact Carol Wenger, executive director of the OSMA-A, at 1-(800) 766-OSMA for registration information. ■

LETTERS TO THE EDITOR

An open letter for help

To the Editor:

The state of Iowa is currently suffering through a devastating natural disaster in the form of record flooding. The flood waters have begun to recede somewhat, and the cleanup has begun in earnest. Tap water has now been restored to Des Moines, though it will not be drinkable for at least another week.

Though it is too early to assess the damage caused by the floods of 1993, it is certain the cost will be very high. One-third of Iowa's corn and bean crops are gone, and hundreds of people have lost everything, including their homes. Business losses, just in the city of Des Moines, could exceed \$700 million. Damage to bridges, roads, sewer systems, etc. in many Iowa cities and towns has yet to be assessed, but is sure to be extensive.

Fortunately, Iowa hospitals and clinics were able to continue functioning on a normal basis. There has been no outbreak of disease, and the death toll has been fairly low considering the magnitude of this calamity. As a preventive measure, volunteers have given tetanus shots to thousands of Iowans in recent days.

The expressions of concerns and offers of assistance that I and members of the Iowa Medical Society staff have received from medical societies across the country have been heartwarming. The support and assistance offered by generous Americans in every state has made this tragedy more bearable for many Iowans. Many of you have asked what you might do to help.

Financial donations are sorely needed to assist Iowans forced out of their homes so quickly that they were able to save nothing. Following are the addresses of several organizations accepting donations:

| | | |
|---|--|--|
| Iowa Cares 666 Walnut Des Moines, Iowa 50309 | American Red Cross 2116 Grand Avenue Des Moines, Iowa 50312 | Salvation Army 1330 6th Avenue Des Moines, Iowa 50304 |
|---|--|--|

ATTN: Brother Phillip

ATTN: Lt. Hellstrom

Again, thank you for your expressions of concern. Pray with us that the heavy rains have ended and that we will come through with no further harm to people and property.

JOHN ANDERSON, MD
President, Iowa Medical Society

Academy responds to article on nurse pilot project

To the Editor:

On behalf of the Academy of Medicine of Cincinnati I must take issue with your item in the July edition of *OHIO Medicine* regarding the nurse practitioner pilot projects.

Dr. John Hutton, a member of our academy and dean of the University of Cincinnati College of Medicine, made it clear during a presentation to our Council that the medical school was committed to establishing a pilot project in Cincinnati. I wrote to Dean Hutton the following day stating that the academy was in agreement with the OSMA that no more sites were needed. I did note, however, that should UC go ahead with their apparent plans, the academy would not oppose them. I ask you and your readers, how could we? On what basis would we mount a campaign to fight our own medical school on this?

I also told the dean that if it came to pass, we believed that local physicians must play a role in shaping the project to assure that the best, long-term interests of patients are met. As a result, Dean Hutton has agreed to formally involve the academy.

Contrary to undercutting the efforts of the OSMA as expressed in your story, we supported the OSMA's position. But, in the face of apparent inevitability, we also took the rational step of securing a place at the table where decisions will be made.

FRANK W. CIANCIOLO, MD
President, Academy of Medicine of Cincinnati

Viewpoint

Get stitches wet?

It always disturbs me when a patient comes in to recheck a laceration repaired elsewhere and I find the cut covered by a heavy bandage with instructions to not get the cut wet. I've never known, however, that keeping stitches dry gives less infection, heals a cut faster, makes less pain, or results in a nicer scar.

So, I was pleased when I read a report of 100 patients who had an incision and stitches. They were told to wash their cut twice a day with soap and water, using their

hands – even to get the cut wet in the shower. The wound was kept dry at all other times.

All the incisions healed promptly without infection or complications. Does that contradict your experience?

W.B. Rogers, MD
Cuyahoga Falls

Write to:

Editor, *OHIO Medicine*
1500 Lake Shore Dr.
Columbus, OH 43204-3824

OHIO Medicine welcomes Letters to the Editor, as well as Commentary articles for consideration, but reserves the right to edit as necessary and to reject those not suited for an OSMA publication.

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HEALTH CARE LAW

JOHN R. IRWIN, M.D.
Attorney at Law

1880 Midland Building
101 Prospect Avenue, West
Cleveland, OH 44115-1027
216-575-0110
Fax: 216-575-0153

Formerly Assistant Secretary and Associate Counsel,
Office of the General Counsel and Resident, Department of General Surgery
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Is joining a group practice for you?

Editor's Note: Managed care is here, managed competition is coming, and more and more physicians are taking cover in group practices.

Can independent practitioners survive in this climate? Should they consider joining a group practice – and if so, what should they know before joining? These are some of the questions we will examine in this new, monthly column, "Group Practice."

If you have specific questions about group practices, or if you wish to see certain topics addressed, please let us know.

Whether you're a young doctor fresh out of school and knee-deep in debt or a seasoned practitioner, the steady income and freedom from paperwork and hassle factors offered by a group can be quite appealing.

Before signing on the dotted line, however, you need to decide if a group practice is right for you.

Jill Foley, OSMA's assistant director for group practice member-

Group Practice

ship, offers some tips for physicians considering joining a group practice.

WHY PHYSICIANS JOIN GROUPS

Ohio physicians, following a national trend, are increasingly moving from solo practice into group practice settings. One of the reasons given is that physicians in group practices can concentrate their efforts solely on the practice of medicine, not paperwork. In a group practice, non-physician staff hired by the group assume responsibility for reimbursement and staffing, positioning the group to respond well to changing reimbursement trends.

"Young physicians are often attracted by the flexibility the groups provide. Group practice physicians don't need to be on-call every day of the week, offering young physicians a more attractive lifestyle and manageable workloads," says J. Craig Strafford, MD, chair of the OSMA Group Practice Advisory Task Force.

SHARING INFORMATION

An added bonus is the freedom/money to attend continuing medical education seminars. It is often more difficult for independent physicians to have this luxury because of loss of income while the physician is away from the office. However, group practices can enable physicians to benefit from educational forums by sponsoring physician attendance on a rotating basis. Through this coordinated participation and information-sharing, all physicians have the opportunity to learn from these programs.

This sharing of information, patients and workload is an important factor in a group practice. Many physicians flourish in the supportive environment. Communicating with other physicians about practice issues and patient care is very necessary to a successful group practice.



Members of the OSMA Group Practice Advisory Task Force are (from left) Peg Stone and Joe Flood, MD, both of the Central Ohio Medical Group, and Doris Konicki, AMA's Group Practice liaison.

COULD YOU WORK IN A GROUP?

"Trained to be independent thinkers, physicians do give up some of their autonomy in order to adapt to a group practice setting," says Foley. "No longer are they the sole decision-maker in an office. Oftentimes there is a board of directors that makes all of the administrative decisions for the group," she says. The group physician becomes a team player. The code they live by is: "What's best for the patient, followed by what's best for the group."

Being a team player means every physician is subject to peer review of every other physician in that group. The poor practices of one physician reflects on all physicians in the group. In other words, group practitioners must share their associates' errors as well as accomplishments. It is the group members' responsibility to keep the practice clean of poor practitioners and to reprimand when necessary.

If you're reluctant to refer patients, a group practice could pose some problems. Some physicians considering a group practice feel they may become more distant from their patients, thus losing the closeness of the doctor/patient relationship. Actual experience of physicians in groups has not found this to be true. The physician remains the patient advocate.

Foley points out that a group practice is similar to a family. The group members must be commit-

ted to nurturing this environment. Like a family, disagreements will arise when physicians work closely together; physicians must openly address conflicts and work toward a solution. There is some truth to the strength-in-numbers theory. Group practitioners admit to having more bargaining power with hospitals, with insurance companies, and with equipment/supply agents.

WHAT ABOUT SALARIES?

When it comes to salaries solo practitioners report higher income levels during their peak years, however those are not achieved at start-up or do not necessarily hold throughout the years. Higher salaries are often forfeited by working in a group, but on the other hand, group practice physicians receive a stable income from the first day of practice and are less likely to retire at an early age, since many groups offer the flexibility of working part-time. Practice start-up costs are also eliminated, yet up-to-date equipment is affordable because the corporation buys it.

Though the trend may be heading in the direction of group practices, it may not be the best move for every physician. The decision remains with the individual.

If you are considering joining a group practice the AMA offers a Group Practice Kit for \$79. Write to: AMA, OP 371890, P.O. Box 2964, Milwaukee, WI 53203. ■

ADVANTAGES:

- Manageable work loads, coordinating schedules
- Relieved from non-medical issues
- Centralized records of patients
- Ongoing medical education and research
- Communicating with other physicians
- Affordable, up-to-date equipment
- Share in profits and deficits
- Strength in numbers, more bargaining power
- Practice as part of team, group consensus

DISADVANTAGES:

- Some sacrifice of autonomy
- Collective responsibility – sharing associates' errors
- Administrative decisions made by executive committee
- Salaries may not be as high as solo practitioner at peak years of practice

Survivor Key: Critical illness insurance pays the living

Survivor Key, a new and unique type of insurance policy known as "critical illness insurance," is now available to OSMA members. This insurance offers enrollees the opportunity to receive a large sum of money upon diagnosis of a critical illness.

American Physicians Life, the only company in the United States to market this type of insurance, has the program up and running and is cosponsoring the program with the OSMA.

Survivor Key pays benefits on diagnosis of most major critical illnesses or upon death. Some are paid at 100% (see sidebar).

HIV caused by accidental injury during professional duties is also covered. The policy will cover 25% of the base policy death benefit for HIV. Those professions covered include: physicians and their staff, hospital staff, and nurses.

LUMP SUM PAYMENTS

The money is paid in a lump sum after the insured is diagnosed with a covered critical illness. This way, the policyholder determines how the money is spent, whether it be for experimental treatment, physical therapy, living expenses or to finance a lifelong dream.

The creator of this insurance concept is Marius Barnard, MD, the world-renowned surgeon who with his brother Christiaan performed the first successful heart transplant in 1967. Dr. Barnard's involvement began about 10 years ago when he became concerned

about how financial hardship invariably followed the successful treatment of a critical illness or operation. The hardship was not due to the cost of the procedure, but rather from the patient's possible reduced capacity to earn an income.

Some of his patients were forced into early retirement or were physically incapable of working, however they still faced mortgage payments and other daily living expenses. Dr. Barnard reasoned, "You should insure yourself because you're going to live, not because you're going to die." During the last decade, this insurance has been successfully offered in Great Britain, South Africa and Australia.

LIFE EXPECTANCY INCREASES

Life expectancy has increased by 66% since 1900. It's a fact that a growing number of people are surviving for longer periods of time after being diagnosed with a critical illness. For example, 67% of heart attack victims survive the initial attack, and 82% of them will survive at least three years.

Though 30% of the U.S. population will develop cancer in their lifetime, the overall five-year survival rate is more than 51%.

Survivor Key is designed to provide survivors with the lifestyle they have become accustomed to. For more information on this new insurance concept, contact OSMA Insurance Agency at 1-(800) 860-4525. ■



Marius Barnard, MD, left, creator of the Survivor Key concept, with OSMA's Executive Director Brent Mulgrew.

Critical Illnesses Covered

- Heart attack
- Stroke
- Life-threatening cancer
- Kidney failure
- Multiple sclerosis
- Major heart surgery (coronary artery, heart valve, aorta; pays 25% and angioplasty pays 10% of base policy death benefit immediately after surgery)
- Paralysis and loss of limbs or sight (total and permanent loss of two or more limbs or total and permanent loss of sight in both eyes)
- Terminal illness (expected to cause death within 12 months)
- Occupational disability (total and permanent disability; pays 10% of base policy death benefit annually for five years, provided they remain totally and permanently disabled; then pays remaining balance in one lump sum)
- Alzheimer's Disease
- HIV in medical personnel (when caused by accidental injury during professional duties; limited to 25% of base policy death benefit)

Multi-year membership approved for medical students

Students attending any of Ohio's seven medical schools can now join the OSMA and AMA for up to four years with one payment of less than \$100.

The OSMA Committee on Membership Marketing and the OSMA Council unanimously approved in late July a multi-year membership proposed by the OSMA Medical Student Section.

The OSMA student membership program will complement the AMA membership, allow partic-

ipation in the activities of the OSMA-MSS, and provide access to all other benefits of OSMA membership, except receipt of *OHIO Medicine*. Students who wish to receive *OHIO Medicine* can subscribe for an annual fee of \$20. A limited supply of the monthly tabloid will be sent to each medical school for free distribution to students.

"The OSMA-MSS membership plan has been packaged for implementation during the orien-

tation programs for incoming first-year students," says Doug Evans, director of the OSMA Department of Membership. "The new dues program will also be offered to current section members and to those we have not been successful in re-

cruting in the past."

The OSMA Membership Marketing Committee commended the student section for their initiative in designing a program that would be marketable to all medical students. ■

| | OSMA | AMA | TOTAL |
|-------------|------|------|-------|
| Four years | \$31 | \$68 | \$99 |
| Three years | \$24 | \$54 | \$78 |
| Two years | \$16 | \$38 | \$54 |
| One year | \$10 | \$20 | \$30 |

Financial seminars target young MDs

Young physicians will discover that they don't have to be a wizard of Wall Street to protect their personal and professional financial interests.

Two half-day workshops sponsored by the OSMA Young Physicians Committee and the AMA have been designed to teach young physicians the financial side of running a practice and personal finances. Experts from the AMA Financing & Practice Services, Inc. and the AMA Investment Advisers, Inc. will provide sound practical guidance on how to minimize problems, maximize investments and provide a secure future for both practice and family.

This program is tailor-made for young physicians who know that in today's economy, financial strategies are critical to their success. Participants are invited to attend either program or both.

The morning session, **Financial Control of Your Practice**, will be from 10 a.m. to noon followed by lunch and **Winning Investment Strategies**, from 1 to 4:30 p.m.

OSMA members pay \$20 per program and non-members, \$40 per program. The workshops will be held on three consecutive days in three locations: September 21 at

the Worthington Holiday Inn, Columbus; September 22 at Airport Marriott, West 150th, Cleveland; and September 23 at Youngstown Club, Youngstown.

Financial Control of Your Practice in 30 Minutes a Day provides strategies physicians can use to get a handle on finances without taking time away from their patients. Physicians will develop a financial management plan that details accounting tasks to be performed daily, weekly, monthly and annually. In this two-hour seminar physicians will learn how coding practices affect reimbursement, what financial indicators they should be looking at, how office policies affect cash flow and how employees – both office staff and physicians – impact practice finances.

Winning Investment Strategies for the '90s and Beyond teaches the principles of investing, and illustrates how to apply these principles to your own portfolio. Physicians will also learn why retirement planning is important.

For more information or to register contact the OSMA at 1-(800) 766-OSMA. ■

The Cleveland Clinic Alcohol and Drug Recovery Center

People come to the Cleveland Clinic for all kinds of reasons.

Confidentially, one of them is chemical dependence.

Call us at 216/444-8739.

THE CLEVELAND CLINIC FOUNDATION

CALENDAR

The OSMA, in association with Conomikes and Associates, Inc., has planned the following practice management workshops for 1993.

Young Physicians – Practice Management Seminars

Winning Investment Strategies for the '90s and Beyond – A half-day financial planning workshop teaching the principles of investing and ways to apply these principles to your own portfolio.

Financial Control of Your Practice in 30 Minutes a Day – This two-hour workshop outlines steps participants can take to gain control over their finances without sacrificing time with patients.

Sept. 21 Holiday Inn, Worthington
Sept. 22 Marriott Airport, Cleveland
Sept. 23 Youngstown Club, Youngstown

How to Run a More Profitable Practice

This one-day workshop is designed to show you the steps to a smarter, leaner and more profitable practice. Learn where your trouble spots are and how to bring them under control.

Sept. 28 Marriott Airport, Cleveland
Sept. 29 Concourse Hotel, Columbus
Sept. 30 Marriott, Cincinnati

Maximizing Your Collection Results

This one-day course is designed for the experienced office manager, billing supervisor and physician manager. The course deals with all aspects of the collection process. Learn to identify the problem, correct it and make certain it doesn't return. The workshop approaches the collections function from the management perspective.

Oct. 12 Dana Center at MCO/Hilton, Toledo
Oct. 13 Sheraton City Center, Cleveland
Oct. 14 Parke Hotel, Canton
Oct. 26 Concourse Hotel, Columbus
Oct. 27 Stouffers, Dayton
Oct. 28 Sheraton, Springdale, Cincinnati

The following are sponsored in cooperation with the AMA's Financing and Practice Services Inc. and the AMA Investment Advisers Inc.

Gearing Up For Retirement

Nov. 9, 10 Columbus Hilton North, Worthington

Starting To Practice Smart

Nov. 10, 11 Columbus Hilton North, Worthington

Joining A Partnership or a Group Practice

Nov. 12 Columbus Hilton North, Worthington

Filing a claim form necessary for SRF refund

If you are a physician who practiced in Ohio between 1975 and 1980, and paid into the Stabilization Reserve Fund, you should have already received from the Ohio Department of Insurance a copy of the SRF proof of claim

form reproduced here. Submitting a proof of claim form is the only way you may be eligible to receive a refund of the SRF monies if a refund is due you.

Only one copy of the form should be submitted per physician.

If you have already sent a claim form, do not send this copy in. If you haven't yet applied for your refund, however, complete the form below and mail it today. The expiration for filing claims is November 12, 1993. ■

SAMPLE

STABILIZATION RESERVE FUND

P.O. Box 267112 Columbus, OH 43226-7112

Phone (614) 888-8901

STABILIZATION RESERVE FUND – FINAL DISTRIBUTION PROOF OF CLAIM

Instructions for Claimants:

- Fill out the POC form completely. (Unless the POC form is fully completed, your claim will be rejected.)
- Fill out the W-9 form completely. (Failure to complete the W-9 form may require the SRF to withhold a portion of your refund.)
- Have the signature of the person signing the claim form notarized.
- If you are making this claim as the personal representative, executor or guardian of a claimant you will need to attach the appropriate documents to the notarized POC.
- If you are making this claim on behalf of a partnership or corporation, indicate your representative status and attach an appropriate resolution attesting to your status to the notarized POC form.
- It is recommended that you keep a copy of this proof of claim form. Return the original to the SRF via certified mail. Note that you will only receive a written response if your claim is rejected.

- Name Of Claimant _____
- Tax Identification Or Social Security Number Of Claimant _____
- Mailing Address _____
- Telephone Number _____

SIGNATURE AND VERIFICATION

I hereby present this claim for refund of monies in the Stabilization Reserve Fund due me or my organization. Such refund is to be distributed in accordance with Section 3701.89 of the Ohio Revised Code and Section 33 of Amended Senate Bill 206 of the 119th General Assembly. I hereby confirm the accuracy of the mailing address, my authorization to file this claim, and the tax identification or social security number which shall be used for reporting the distribution to be received by me or my organization to the Internal Revenue Service. I understand this claim must be postmarked by Nov. 12, 1993 or the claim shall be forever barred as to all parties and no payment shall be made nor any legal action or lawsuit shall be maintained on this claim.

Signature of claimant and date

Sworn to and subscribed before me this
_____ day of _____, 1993.

Signature and seal of notary public

Chicago forum will address CME accreditation

The Continuing Medical Education Accreditation staff of the state medical societies and the Committee for Review and Recognition of the Accreditation Council for Continuing Medical Education will meet Sept. 10-11 in Chicago. This annual conference is designed to address the needs identified by a survey of the CME Accreditation staffs of the state medical societies.

Albert N. May, MD, chair of the OSMA Committee on Education and OSMA staff members, Gail Dodson and Janet Orbaker, along with a representative of the Illinois State Medical Society, will present a workshop on "Training CME Site Surveyors."

Members will also discuss uniformity of the Essentials and Standards from state to state; joint sponsorship issues; the new random monitoring process; evolving interpretations of the ACCME Standards for Commercial Support of CME; and other issues that may impact regulatory deference by the FDA.

OHIO Medicine will keep you posted on further developments from this meeting. ■

Changes in health reform focus of AMA conference

New and experienced medical staff leaders will hone their leadership skills at the fourth annual Medical Staff Leadership Conference: Managing Change, sponsored by the American Medical Association in cooperation with the Medical Association of Georgia and the Florida Medical Association.

The three-day conference, October 1-3, in Naples, Florida, provides physicians with the knowledge and tools to deal with the changes surrounding health-system reform while gaining a greater understanding of health policy and medical practice issues.

For more information or to register, call 1-(800) 621-8335. ■

OSMA In Action

A round-up of the association's activities...

■ Group billing program

In response to information received from group practice administrators, the OSMA Department of Membership has coordinated a group billing program for the 1994 membership year. Twenty-one group practices in Ohio indicated an interest in receiving a single invoice for membership dues, affecting more than 700 physicians statewide. The OSMA is working in cooperation with the local county medical societies to provide the group invoice. Not only will this make the billing process more efficient for the groups and OSMA, but new members should be gained in the process.

■ Physicians earn CME credits

A number of Ohio physicians, 370 to be exact, have earned CME credit by reviewing either the Domestic Violence or Child Abuse Prevention handbooks. The third part of the campaign, Elder Abuse, which kicks off in November, offers physicians an opportunity to self-designate Category 2 CME credit for reviewing the handbook.

■ BWC group rating program

OSMA members are finding a significant way to trim their practice costs is to join the OSMA's Workers' Compensation Group Rating Program. Enrollment for the third year of the program was completed in July with 670 new applicants. Since its inception in 1992, the program has seen continual growth. By the end of the second year, there were 1,330

physicians enrolled, which represents 3,990 OSMA members. This is up from 955 physicians in the first year, representing 2,865 members. The nearly 4,000 Ohio physicians participating in the group rating program for 1993 will reduce their annual Workers' Compensation premium payments as much as 50% or more – saving a total of more than \$2 million.

■ Sports medicine subcommittee meets

The Subcommittee on Education, Joint Advisory Committee on Sports Medicine (JACSM) met recently to discuss problems plaguing sports medicine programs for interscholastic coaches as required by the Ohio State Board of Education. It seems that many administrators are not holding coaches accountable for completing the required programs. Plus, several of the coaches expressed that they are bored and feel there is no need for the programs. A committee was formed by the Ohio Department of Education Division of Teacher Education & Certification, including representatives from the JACSM as well as program providers and program recipients, to consider changes. Other states will be contacted to see how similar programs are administered, monitored and enforced. Some of the recommendations from JACSM include: that the yearly re-evaluation course be replaced by a four-hour recertification course every two years; that coaches receive continuing education units for completion of the four-hour recertification courses; and that the turnaround time for certificates of completion be shortened. *OHIO Medicine* will keep you posted on any further developments. ■

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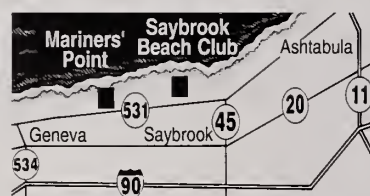
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OSMA schedules media forum on health-care reform

The OSMA, in conjunction with the Ohio Hospital Association, is sponsoring a forum on health-care reform for the news media and others.

This forum will bring together hospital officials and physicians with reporters and media executives to discuss health-care reform and get acquainted with each other's perspectives on the issue.

The all-day conference, entitled "Health Care and the Media: Reporting Forum," is being held in conjunction with the Ohio Association of Broadcasters and the Ohio Newspaper Association on September 27 at Villa Milano Banquet Center in Columbus.

Forum speakers will include representatives from the OSMA, and the Ohio Hospital Association; and a panel of news media representatives.

To register, please contact the Ohio Hospital Association at (614) 221-7614. ■

Colleagues

HERMAN I. ABROMOWITZ, MD, Dayton, was re-elected to the AMA Council on Medical Services for a two-year term.

ROBERT T. BROWN, MD, Columbus, was elected president of the North American Society for Pediatric and Adolescent Gynecology. Dr. Brown is chief of the section of adolescent medicine at Children's Hospital.

GREGORY A. BURROWS, DO, Niles, was elected chief of staff at Warren General Hospital.

CASS CULLIS, MD, Troy, was elected chief of staff at Stouder Memorial Hospital.

JOHN A. DRSTVENSEK, MD, Columbus, was elected president of the Ohio chapter of the American College of Emergency Physicians. Dr. Drstvenssek is the medical director of the department of emergency medicine at Park Medical Center.

STEWART DUNSKER, MD, Cincinnati, was named a director of the American Board of Neurological Surgery. Dr. Dunsker, a neurological surgeon, is a professor of clinical neurosurgery and director of the neurosurgery department's division of the spine at the University of Cincinnati Medical Center. He is a past president of OSMA.



Dr. Dunsker

EDMUND W. JONES, MD, Cincinnati, won re-election to an at-large position on the AMA Hospital Medical Staff Section Governing Council.

HOWARD L. LEVINE, MD, Cleveland, was elected president of the Academy of Medicine of Cleveland. Dr. Levine is chief of the section of nasal-sinus surgery at Mt. Sinai Medical Center.

BENJAMIN M. MARAAN, MD, Cincinnati, was elected president of the medical staff at Providence Hospital.

DAVID B. NASH, MD, Salem, was elected president of the medical staff at Salem Community Hospital.

RICHARD ROLAND, MD, Youngstown, was appointed president of the professional staff at Youngstown Hospital Association.

VICTORIA N. RUFF, MD, Columbus, was elected president of the Academy of Medicine of Columbus and Franklin County. Dr. Ruff is associate director of critical care



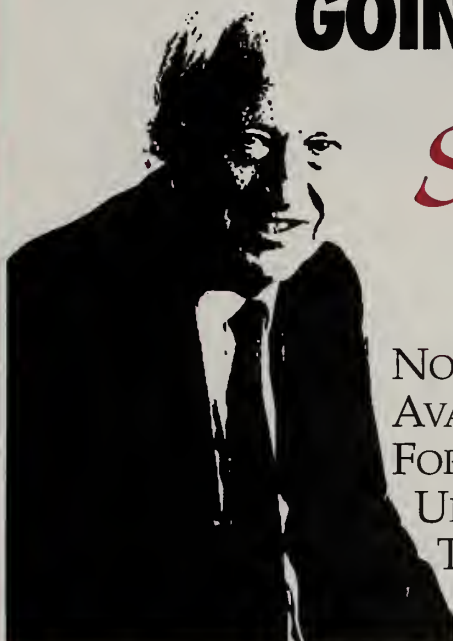
Dr. Ruff

services at Riverside Methodist Hospitals and an assistant clinical professor at the OSU Hospitals' Department of Medicine.

EDWARD SCHIRACK, DO, Canton, was elected chief of staff at Doctors Hospital. ■

The Merits of Membership:

"NOT BECAUSE YOU ARE GOING TO DIE, BUT, BECAUSE YOU ARE GOING TO SURVIVE."



Dr. Marius Barnard

Over a quarter of a century ago, renowned cardiologist, Marius Barnard assisted his brother Christiaan in performing the first human heart transplant. It was his realization that such a life saving medical advancement, while preserving life, created devastating financial impact on the surviving patients' struggle for recovery. Therefore, he created an insurance concept that allows critically ill patients and their families to have financial peace of mind even if their ability to support themselves is impaired.

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AMA trustee addresses medical students

Robert McAfee, MD, honorary OSMA member and a member of the AMA's Board of Trustees, left his Maine home for Ohio once again – this time to address those attending the "Meet the Students"

reception held August 31 at the Ramada University Inn in Columbus. The event was organized by the Academy of Medicine of Columbus and Franklin County, and sponsored by the OSMA Medical Stu-

dent Section.

"Until this year, the 'Meet the Student' event was like a residency fair," says Tim Reeder, president of the OSMA-MSS and a third-year medical student at Ohio State

University's College of Medicine. In the past, third- and fourth-year residents were invited annually by the Franklin County Academy to come and mingle with academy members.

"The idea was for students to meet physicians who are already in practice and develop a relationship with them," says the academy's Libby Moore, who has organized the three-year-old events.

The concept fits neatly into the mentoring program, which the student section has recently launched (see Association News section in the June issue of *OHIO Medicine*), but this year, students thought the audience for the event should be broadened.

"We thought it would be nice if we could start earlier to get students hooked up with physicians who are active in organized medicine," says Reeder. That's why, this year, first- and second-year students were invited to attend.

More than 100 medical students turned out for the affair – along with a large representation of academy members. Whether or not mentoring occurs, the event was a success, by any terms, and will be repeated next year. ■

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Child Abuse speaker's kit available

The OSMA Department of Communications has produced a speaker's kit for physicians and Alliance members to use when speaking to groups about child abuse.

The kit is available free of charge to OSMA members and Alliance members. It includes a slide show with a script for a physician audience and a script for a general audience. The kit also includes a set of tips for communicating effectively.

To obtain a copy of the TrustTalk Child Abuse Speaker's Kit, contact Connie Lechleitner, associate director of Communications, at 1-(800) 766-OSMA. ■

Hamilton County debates homicide ruling

A Hamilton County grand jury decided not to bring charges against family members in the case of a woman who died in March of an acute morphine overdose.

Investigators believed the overdose may have been a case of mercy killing, and the Hamilton County coroner listed the woman's

official cause of death a homicide.

The woman, a terminally ill patient who suffered from cancer of the esophagus, had ingested more than 10 times the lethal amount of morphine. The cause of the wo-

man's death was not in question. The grand jury was convened to determine whether or not there was an intent to kill by the caregivers.

Members of the grand jury were

apparently not convinced by the evidence presented.

Family members will petition the court to have the coroner's ruling of homicide removed from the death certificate. ■

Dayton physicians sue over sale of Western Ohio

Four Dayton physicians have filed suit in Montgomery County Common Pleas Court alleging that directors and principal shareholders of Western Ohio Health Care Corp., the area's largest HMO, fraudulently enriched themselves by acting on inside information. These parties did so, the suit continues, at the expense of those physicians who kept the company afloat during a difficult financial period in the mid-1980s by giving up their fees.

It's alleged that the defendants acted on inside information.

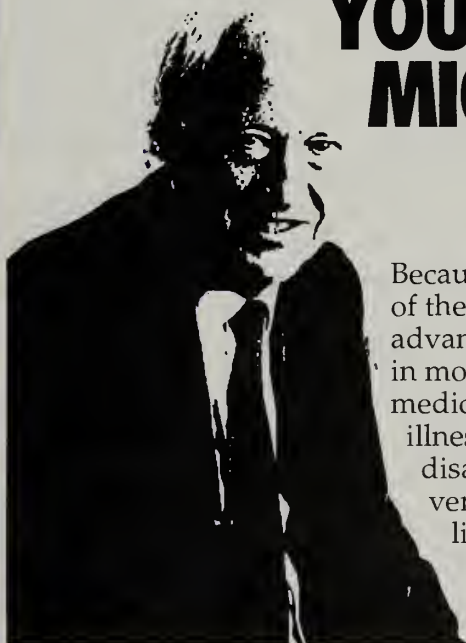
The plaintiffs argue that, had they been informed that their fees were never going to be returned, they would have exercised their right to exchange their fees for Western shares. But, the suit continues, Western Ohio's board failed to disclose its intent to never return the fees before entering into the sale agreement with United Health Care.

At the time of the sale, those who had purchased the shares of stock at \$1 a share profited when United Health Care paid shareholders \$42.50 a share for the company.

The lawsuit seeks \$14 million for breach of contract, plus punitive damages of \$33 million. The suit also asks that proceeds from the sale be spread among more than 900 area physicians. ■

The Merits of Membership:

"YOU MIGHT SURVIVE, BUT THE QUALITY OF YOUR LIFE MIGHT NOT."



Dr. Marius Barnard

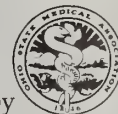
Over a quarter of a century ago, renowned cardiologist, Marius Barnard assisted his brother Christian in performing the first human heart transplant. It was his realization that such a life saving medical advancement, while preserving life, created devastating financial impact on the surviving patients' struggle for recovery. Therefore, he created an insurance concept that allows critically ill patients and their families to have financial peace of mind even if their ability to support themselves is impaired.

Because of the advancements in modern medicine, many

illnesses that were once terminal are now disabling conditions. Consequently, the very treatment that now saves patients' lives, can financially compromise or destroy all they've ever worked for.

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Browning case alerts hospitals to negligent credentialing

The Ohio Supreme Court's recent decision in the *Browning v. Burt* case will dramatically affect peer review in the state. The decision is not a very popular one with Ohio physicians.

As a result of this decision hospitals and their medical staffs are more susceptible to lawsuits from patients claiming negligent credentialing.

Ohio law does not offer any immunity to a hospital regarding a negligent credentialing action brought by a patient.

HOSPITAL NEGLIGENCE

Browning v. Burt (1993) involved a claim against St. Elizabeth Medical Center in Dayton, rising out of activities of "love doctor" James C. Burt, MD. The claim against the hospital is that it negligently retained Dr. Burt as a member of its hospital medical staff even though it was common knowledge that Dr. Burt was regularly performing unnecessary and experimental "vag-

inal reconstructive surgery" on his patients.

The Ohio Supreme Court concluded that the appropriate statute of limitations is two years.

The statute of limitations for negligent credentialing is now indefinite.

The statute of limitations for general medical malpractice actions is one year from the time the patient knew or should have known he/she was injured. St. Elizabeth's argued that the general one-year statute of limitations should apply.

In addition, the court held that the two-year period does not begin to run until the "victim" knows or discovers that he or she was in-

jured as a result of the hospital's negligent credentialing practices.

COURT CREATES "ALERTING EVENT"

In the *Browning* case, the court created the "alerting event," which is the discovery of some information that would warrant the investigation of a hospital's credentialing process.

It is unlikely a "victim" will know about a potential negligent credentialing claim until after a medical claim is filed against a physician. Consequently, the statute of limitations for negligent credentialing is now indefinite.

As a result of the *Browning* decision, the risk to remove a substandard practitioner from the medical staff of a hospital clearly outweighs any potential adverse consequences associated with any claims that might be filed by the practitioner.

OHIO Medicine will keep you posted on further details. ■

Court rules HMOs can't file for bankruptcy

The Seventh U.S. Circuit Court of Appeals in Illinois recently ruled that, under Illinois law, HMOs are insurance companies, which excludes them from federal bankruptcy protection. This means that, in Illinois, state insurance laws rather than federal bankruptcy laws will govern liquidation or restructuring of insolvent HMOs. Courts would probably reach a similar result if this issue would be litigated in Ohio.

Ohio law specifically requires that any rehabilitation, liquidation or conservation of a health maintenance organization be treated as the rehabilitation, liquidation or conservation of an insurance company. Any rehabilitation, liquidation or conservation of an insurance company must be conducted under the supervision of the Ohio Department of Insurance. ■



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AMA opposes fee increase by DEA

The AMA has filed a lawsuit against the DEA contesting the final rule implementing a registration fee increase that nearly quadruples registration fees for manufacturers, dispensers, distributors and prescribers of controlled substances. The increase is to fund a drug diversion control program.

While the AMA supports the idea of a drug diversion control program, it does not believe the fee increase complies with federal law. The objections are that the program

has not been defined, the relationship between the program and those affected has not been explained, and the fee increase has not been justified. The AMA and several health-care associations

joined in the suit hope to obtain a court order invalidating the final rule and requiring proper design and implementation of the program.

According to Mike Ile, general counsel for the AMA, the DEA has not responded to the complaint. He

said that physicians receiving a bill for the higher fee should pay it. The filing of the lawsuit does not preclude payment of the fee. In the event the AMA prevails in this matter, physicians should receive a refund. ■

New 'Guide to Ohio Law' is bigger, better

After six months of reviewing statutes and drafting new text and reorganizing, the OSMA's Legal Department has completed revisions on the ever-popular *Physician's Guide to Ohio Law*.

"The new edition will be more user-friendly," says Katrina

*The new edition
arranges the laws
into sections.*

English, director of OSMA's Legal Department. She points out that instead of listing information in alphabetical order, the fifth edition arranges the laws into sections.

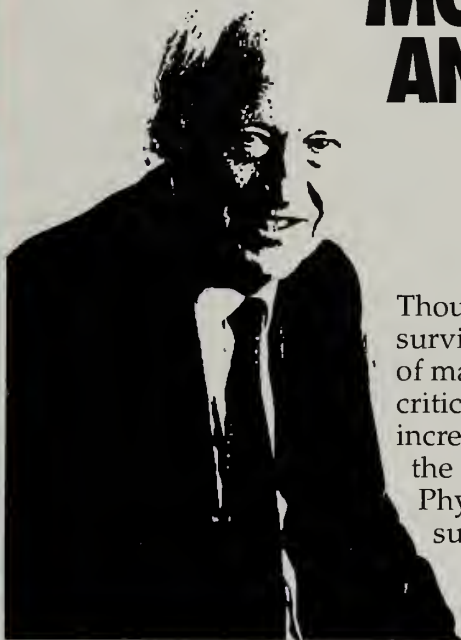
The guide, a comprehensive collection of Ohio laws regarding the practice of medicine, is intended to alert physicians to Ohio laws that affect various aspects of their practice. Also included in this edition are legal fact sheets providing practical information to physicians.

The new *Physician's Guide to Ohio Law* also provides ethical opinions from the American Medical Association and the AMA's ethical statements, plus revised medical board position papers and other documents.

To obtain a copy of the updated version of *Physician's Guide to Ohio Law*, complete the postcard found elsewhere in this issue. ■

The Merits of Membership:

**"I BELIEVE
PHYSICIANS NEED
THIS TYPE OF PRODUCT
MORE THAN
ANYBODY ELSE."**



Dr. Marius Barnard

Over a quarter of a century ago, renowned cardiologist, Marius Barnard assisted his brother Christian in performing the first human heart transplant. It was his realization that such a life saving medical advancement, while preserving life, created devastating financial impact on the surviving patients' struggle for recovery. Therefore, he created an insurance concept that allows critically ill patients and their families to have financial peace of mind even if their ability to support themselves is impaired.

Though the survival rates of many critical illnesses have increased considerably, the financial risk of the recovering patient is tremendous. Physicians, for example, who've built successful practices and achieved an enriched lifestyle may have more to lose than anyone. Particularly if critical illness destroys their ability to practice medicine and maintain their quality of life.

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CMIC bases reimbursement on RBRVS

Community Mutual has become the first private insurer in Ohio to base its reimbursement on an RBRVS system.

Company officials say the new system, implemented July 1, should prove advantageous to physicians because it eliminates individual provider profile updates ("usuals") and includes more accurate pricing levels, say company officials.

30+ CONVERSION FACTORS

New reimbursement levels were calculated by considering the relative value and original charge of provider services, then attaching a conversion factor – the current plan has over 30 – to the payment.

"Those services for which we were paying higher reimbursement now have higher conversion factors," says Todd Ertel, director of CMIC's Provider Reimbursement, "so we didn't do any gerrymandering of the original payment." In other words, in many cases reimbursement levels will stay about the same.

Company officials say of the top 1,000 most frequently used codes,

none was allowed to increase or decrease by more than 10%; lower frequency codes will be allowed to rise or fall without this cap. According to company projections, of the top 1,000 codes, 37% will increase, 28% will decrease and 35% will remain the same.

Ertel maintains that the conversion to RBRVS will not mean an overall decrease in reimbursement to providers. "You may notice some changes on individual codes," he says, "but not over a range of codes." What some physicians may lose in one area, for example, may be made up by a service they perform in another.

Ertel also stresses that Community Mutual is not implementing a Medicare RBRVS system. "What we're *not* doing is going to a Medicare system where there is a single conversion factor." In fact, he adds, not only does CMIC's 30+ conversion factors allow for more equitable reimbursements, but they will be substantially higher than Medicare's.

Whether or not providers will embrace RBRVS, it is the wave of the future, says Ertel. "Most payors will be on some kind of RBRVS

system in the next few years. We think this is what we have to do."

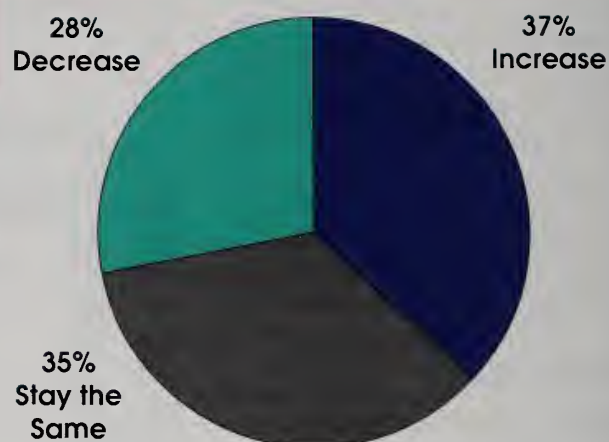
While that may be true, Bill Fry, director of OSMA's Ombudsman Department, says the OSMA is taking cautious appraisal of the situation.

"It's fairly obvious at the national level that RBRVS is going to be used," says Fry. "The question is, can it be used in a fair and equitable manner?"

SYSTEM APPEARS FAIR

Fry says he was surprised at the number of conversion factors CMIC is using, but "they don't seem to intend to create a crisis or chaos," as has been the case in California. In that state, Blue Cross of California recently announced

How the Top Codes Are Affected



its intention to cut specialty fees across the board by 5%-6%, and physicians are threatening to form their own insurance companies.

"Community Mutual said to us, 'We want it to work, we want to be fair,' and they seem to be doing that," says Fry, adding that "The proof of the pie is in the eating, and we'll have to see how it plays. We don't have any way of practically evaluating it yet." ■

ODHS changes 6780 claim form

Physicians who file the 6780 claim form with the Ohio Department of Human Services should know that the department has revised the current form.

The revised form, which became available around August 1, includes several minor changes, however they account for two main reasons claims are denied – eligibility issues and information billed in the incorrect block.

The following changes have been made:

- Block nine and 10 have been combined and renamed "Billing Number," which accommodates the recipient's 12-digit identification number.
- Block 10, formerly the ADC number block, has been deleted, and the remaining block numbers all drop by one number.

- Blocks 19-21 become 18-20 and are relabeled "Medicare Approved Amount," "Medicare Deductible" and "Medicare Co-Insurance" respectively.

- Formerly unlabeled block 25 becomes block 24, which is now labeled "Consent Date" (which is used only for departmental use – leave blank).

The new ODHS form also includes the update claim submission address, which is P.O. Box 2644 for all provider service codes (with the exception of Medicare/Medicaid crossover provider service code F, which is P.O. Box 2338).

While further billing instructions and training is expected, physicians who have questions may call the Provider Relations Section at 1-(800) 686-1564 or (614) 466-7960. ■

Bogus lab inspector at large

The OSMA has learned that there may be a fraudulent laboratory inspector preying on Ohio doctors.

The Health Care Financing Administration has indicated that an individual may have been falsely representing himself as a HCFA CLIA laboratory inspector in Ohio and other states. This person may contact the laboratory either by telephone or in person and announce a future inspection for the CLIA initial inspection. After describing the potential fines for failure to pass inspection, this individual may recommend a consulting firm to assist the laboratory in preparing for the inspection.

Please be advised:

1. Ask to see identification. All CLIA inspectors carry identification cards for either HCFA, if the laboratory is a federal facility, or identification cards

from the Ohio Department of Health. *Do not accept a business card as identification.*

2. Be aware of the inspection time limits. The notification time for a CLIA inspection is a maximum of 10 days. *Any time frame exceeding 10 days violates HCFA procedures.*
3. Be suspicious if fines are indicated. The first CLIA survey is intended to be educational. *No fines are assessed unless the inspector believes immediate jeopardy exists.*

If you suspect you have been contacted by a fraudulent inspector or if you wish to verify the scheduling of any CLIA survey in Ohio, call the Ohio Department of Health, Laboratory Certification Program at (614) 644-2845. ■

An update on mammography's new limited charge

On July 1, a provision of House Bill 142 – the mammography screening bill that was passed last year – became effective. Ohio's insurers are now required to cover screening mammograms. The new law establishes a maximum reimbursement of \$85 for this procedure. Balance billing is not permitted. In the July issue of *OHIO Medicine*, the OSMA published a series of questions and answers to assist physicians in answering questions about screening mammography coverage and reimbursement.

The OSMA continues to receive questions about this new law. Here are some of the more frequently asked questions and answers.

Q. What type of insurers are required to provide coverage for screening mammograms?

A. The new law states that "every individual or group health maintenance organization contract" (Ohio Rev. Code Sec. 1742.40); "every policy of sickness and accident insurance" (Ohio Rev. Code Sec. 3923.52) and "every public employee benefit plan" (Ohio Rev. Code Sec. 3923.53) must provide benefits for the expenses associated with screening mammography. In addition, some self-insured employers who provide health-care coverage, in whole or in part, for their employees under a policy of sickness and accident insurance must also provide coverage for screening mammography. Medicaid is also required to cover screening mammography if federal funds may be used for this purpose.

Q. Are Medicare gap-filler or supplement policies required to cover screening mammography?

A. No. The following types of insurance policies are excluded from the requirement to provide coverage for screening mammograms: specific disease or accident-

only policies, hospital indemnity policies, Medicare supplement or other policies that provide supplemental coverage.

Q. This new law applies to "screening mammography." Does the law define "screening mammography"?

A. Yes. Ohio law defines "screening mammography" as a "radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the X-ray examination of the breast using equipment that is dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, film and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast." The statute specifically states that the term "screening mammography" does not include "diagnostic mammography."

Q. How do I make sure that I receive payment?

A. It would be wise for physicians to reach an accommodation with their hospital and third-party payors concerning the "who's," "hows" and "wherefores" of billing for screening mammography services. Without such an agreement, it's likely that the first one to bill (be it hospital or physician) will be paid and the second one will either receive only partial payment or no payment at all.

Q. Should physicians consider the \$85 cap to apply only to the technical component, and feel free to bill the patient their usual professional fee for interpreting screening mammograms?

A. No. The Ohio Legislature definitely intended for the \$85 to be the total cost for mammography screenings. Physicians are expressly limited from billing for any part of the screening mammography service by the language contained in the bill. If you are aware of any hospitals that are encouraging physicians to balance

bill their patients, please notify the OSMA's Legislative Department.

Q. How should physicians bill for screening mammography? Should the physician charge his or her usual fee? What if the physician's usual fee for a screening mammogram is \$125?

A. The statute provides that the "benefit paid (for a screening mammogram) shall constitute full payment." This means that the physician is permitted and encouraged to charge his or her usual fee, in this example \$125. The physician is now required, however, to accept the benefit paid by the insurance company (an amount not to exceed \$85) as payment in full. This means no balance billing. ■

If you have questions about any story in the Third-Party Update section, contact the OSMA Ombudsman staff at 1-(800) 766-OSMA.

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| February 20 | Depart San Juan 10:00 pm | February 24 | At Sea-Lectures |
| February 21 | At Sea-Lectures | February 25 | Tortola/Virgin Gorda 7:30 am - 6:30 pm |
| February 22 | Aruba 8:00 am - 5:00 pm | February 26 | St. John/St. Thomas 6:30 am - 6:00 pm |
| February 23 | Curacao 8:00 am - 5:00 pm | February 27 | San Juan arrive 8:00 am |



OHIO Medicine celebrates 'Women in Medicine' month

Editor's Note: *September is officially Women's Health Month – but OHIO Medicine decided to take some liberty with that title and honor "Women in Medicine Month" instead. We've gathered together some appropriate items, and present them here as a tribute to all women who practice medicine in Ohio.*

MOTHER-DAUGHTER TEAM

Mary Walborn, MD and her daughter Patricia A. Gannon, MD, are one of those rarities in medicine – a mother-daughter medical team. Both doctors specialize in primary internal medicine.

Dr. Walborn began her pre-med training in Philadelphia when her daughter was in kindergarten. By the time Dr. Walborn was in medical school at the University of Michigan in East Lansing, Dr. Gannon was accompanying her mother to classes on days off from grade school and junior high

school.

No wonder, then, that when Dr. Gannon reached college, she decided to follow in her mother's footsteps. Dr. Gannon graduated from the Medical College of Ohio at Toledo in 1990.

Dr. Gannon joined her mother's practice, located in Lakewood, in July.

MEDICAL-STUDENT ELECTED TO AMA COUNCIL

Elaine Holstine, a medical student from Wright State University's medical school, was elected to serve as chair of the 1993-94 Medical Student Section Governing Council during the AMA's 1993 Annual Meeting.

Holstine replaces another Ohio medical student, Jane Uva, who will pursue her MPH at Harvard, but she will retain a seat on the Council as immediate past chair. ■



Women Physicians on the Move

From left: Victoria Ruff, MD, president of the Academy of Medicine of Columbus and Franklin County, Claire Wolfe, MD, president-elect of the OSMA, and Mary Jo Welker, MD, president of the Ohio Academy of Family Practitioners, show that women physicians are making their mark on organized medicine.

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Med schools reporting higher number of women enrollees

For the first time in its 150-year history, the number of female medical students is rivaling that of males at Case Western Reserve University School of Medicine.

In the most recent graduating class, men outnumbered women

Male-female enrollment should soon reach 50-50.

81-63. But in upcoming classes, the number of women enrollees either equals or slightly surpasses that of men.

Albert C. Kirby, MD, associate dean for admissions and student affairs at CWRU's medical school, says the numbers are encouraging, if not slightly misleading. "It tends to go up and down. It's more cyclical," says Dr. Kirby. "For instance, in 1990 and 1992, we had more women enrollees than men, but in between, in 1991, we had more men. You do get a variation."

Dr. Kirby, says the increase in female medical students has been slow but steady.

"It was about the mid-'70s when the number of women started to increase," says Dr. Kirby, "and by 1980 women represented about one-third of enrollees. Since then it's crept up a percentage point every year."

Today, women represent 39.4% of medical students nationwide, though, Dr. Kirby says, "I expect it would be 50-50 nationwide in the next few years."

And while the increasing number of women is a good sign, Dr. Kirby says that their relatively low representation in recent years should not

be blamed on medicine, per se, but rather society.

"It just doesn't hold water that medical school admissions have been discriminatory toward women," says Dr. Kirby. "What does hold water is that women were discouraged by outside forces from applying to medical school."

Whether the numbers indicate a growing trend in the medical field or are a reflection of society as a whole is up for debate.

"I think it's across the board," says Dr. Kirby. "Young women in college see medicine as a viable career, just as they see other careers as viable." ■

Women physicians host call-in show

A panel of women physicians from the Academy of Medicine of Cleveland will host the fifth annual "Health Choices for Women" program Sept. 11.

The event, which salutes national Women's Health Month, will take place Sept. 11 from 1 p.m. to 4 p.m. at Beachwood Place shopping mall.

The program will also feature a two-hour radio call-in show from 2 p.m. to 4 p.m. Physician specialists will be interviewed on such topics as sexually transmitted diseases, skin cancer, hair loss, osteoporosis, menopause and immunizations for children. ■

Nurses-midwives want to increase their numbers

Nurses and physician assistants aren't the only allied professionals eager to take advantage of the new focus on access raised by the health-care reform debate.

The American College of Nurse-Midwifery recently issued a report calling for an investment of \$31 million or more to increase the number of certified nurse-midwives in the nation. Currently, 3,500 CNMs practice nationwide. Ohio has 90 nurse-midwives, 72 of whom presently hold licenses. The ACNM, however, wants to see the total number of nurse-midwives raised to 10,000 by the year 2001.

Nurse-midwifery, says the report, would provide more care in underserved areas. The report estimated that it costs one-fourth as much to

educate a midwife as it does to graduate an obstetrician – and CNM malpractice premiums are lower.

Ohio has an accredited mid-

wifery graduate program in Cleveland. All certified nurse-midwives are registered nurses with graduate-level education. They are licensed, and may practice legally

in Ohio as long as they have contracted with an obstetrician who will take over in emergency situations. Uncertified midwives, by law, can't practice in Ohio. ■

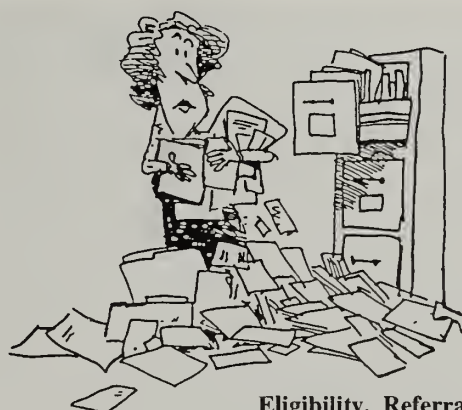
Ohio physicians launch new medical group

Nino M. Camardese, MD, Norwalk, Kenneth D. Cristmas, MD, Dayton and Carl S. Wehri, MD, Delphos were present for the first meeting of the Medical Action Committee for Education, a new group aimed at preserving the quality of U.S. health care.

MACE has five major goals:

1. Establish a grass-roots education program for patients and doctors.
2. Defend and promote the private sector of medicine and research-based pharmaceutical companies.
3. Fight against the establishment of price controls for physicians and prescription drugs.
4. Keep medical care from being rationed in the U.S.
5. Support the establishment of medical savings accounts and medical IRAs.

About 400 health-care professionals, many of them physicians, attended MACE's first meeting. The program included presentations on different health-care systems, managed competition and quality care. ■



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West Virginia provider tax drives physicians to Ohio

Some West Virginia physicians are closing their practices and moving their businesses to Ohio, thanks to a Medicaid provider tax that was passed by the West Virginia Legislature and signed into law in June.

"West Virginia is the first state that is trying to fund health care for the poor by taxing the very people who provide care at reduced rates, instead of distributing the burden among all taxpayers in the state,"

wrote the West Virginia State Medical Association in an "important notice," distributed to its members in its monthly newsletter, "Wesgram."

SUITS MAY FOLLOW

The WVSMA went on to outline in its notice two forms of action it is taking in response to the new law. First, it has retained legal counsel and says it will institute action against the Tax Commissioner if the 200% penalty provision for underpayment of tax is assessed against any physician who, in good faith, followed the department's directions for tax calculations or used reasonable diligence in calculating the tax due. The provider tax was due June 15, and, adding insult to injury, the tax had to be paid despite the fact that the state was months behind in reimbursing Medicaid providers.

Second, the WVSMA's legal counsel has been directed to obtain information from appropriate government offices concerning reimbursement cuts, delays in payment and other areas of state non-compliance with state and federal law. The information is to be gathered in anticipation of a suit that is likely to be filed against the Office of Medical Services (Medicaid) and the Tax Commissioner, as well as others who, "by their conduct, appear to have violated the civil rights of association members and other health-care providers," the WVSMA writes in its notice.

EXODUS BEGINS

Meanwhile, West Virginia physicians are exiting the state and opening offices in Ohio.

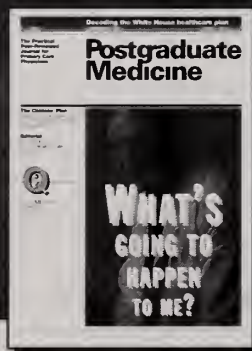
"We've already had one doctor move entirely to Marietta, and many others already have offices there and are moving a lot of their practices across the river," says David Avery, MD, president of the Parkersburg Academy of Medicine in a recent AP story.

The same news report cited three other physicians who have made the exodus into Ohio.

Those physicians, like Dr. Avery, who elect to stay in West Virginia, are investigating the possibility of becoming salaried employees for local hospitals so that the hospitals would pay the tax. But even Dr. Avery sees the appeal of a move to Ohio. "If we cross the river, our malpractice insurance goes down by a third, there's no tax, and the reimbursement rates are higher." ■

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MEETING TO DECIDE
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AND YOU WEREN'T
INVITED**

Read the September 15th and November 15th issues of POSTGRADUATE MEDICINE to get details of the Clintons' healthcare plan and to learn how it will affect you and what you can do about it.



JCAH will release performance studies to public

Soon, members of the public will be able to compare local hospital services by calling the Joint Commission on Accreditation for Healthcare and tapping into that organization's performance-monitoring data bank.

The move has been made possible by two recent actions of the JCAH Board:

1. The establishment of a national database to compare performance and foster improvement in health-care organizations. During 1994 and 1995, hospitals will have the opportunity to voluntarily participate in the system.
2. The approval of change in the Confidentiality and Disclosure Policy that will, for the first

time, permit direct public access to organization-specific performance information. In 1994, publicly disclosed information will provide ratings of

standards compliance in areas such as nursing, infection control, patient rights and life safety – all provided on a comparative basis.

What next? The accreditation of health-care networks. Watch future issues of *Ohio Medicine* for more news on this event – expected to take place by January 1, 1994. ■

Specialists at risk of dependency

Can a physician's specialty place him or her at risk of impairment from chemical dependency? According to data collected by the Ohio Physician Effectiveness Program, availability can be a factor in determining who may become a substance abuser.

Presented here are the percentages, by specialty, of those enrolled in OPEP, and how that compares to the percentage of that specialty in the state.

Anesthesia

12.2% in OPEP; 6.9% of specialty in state

Family Medicine

17.4% in OPEP; 14.1% of specialty in state

Psychiatry

8.7% in OPEP; 6.4% of specialty in state

Emergency Medicine

7.8% in OPEP; 6.3% of specialty in state

Orthopedics

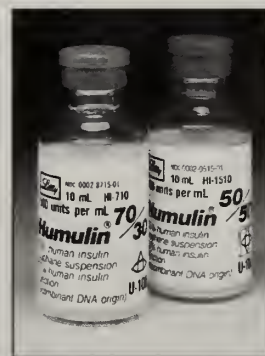
5.2% in OPEP; 4.3% of specialty in state ■




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to superior medical practice and medical education. Interested candidates should forward a curriculum vitae to David L. Bronson, MD, FACP, Chairman, Department of General Internal Medicine, Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195.

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BITUARIES

LOUIS BARNETT, DO, Kettering; Chicago College of Osteopathy, Chicago, IL, 1956; age 70; died June 20, 1993; member OSMa and AMA.

FLOYD M. BEMAN, MD, Columbus; Ohio State University College of Medicine, 1943; age 74; died June 20, 1993; member OSMa.

HENRY BROWN, MD, Madison; Hahnemann Medical College of Philadelphia, Philadelphia, PA, 1939; age 79; died July 2, 1993; member OSMa and AMA.

KEITH A. CALLENDER, MD, Dayton; Loma Linda University School of Medicine, Loma Linda-Los Angeles, CA, 1972; age 47; died June 10, 1993; member OSMa and AMA.

WALTER L. CRUISE, MD, Zanesville; University of Cincinnati College of Medicine, 1925; age 96; died June 17, 1993; member OSMa and AMA.

CHARLES N. HOYT, MD, Hilton Head, SC; Columbia University College of Physicians & Surgeons, New York, NY, 1943; age 76; died June 25, 1993; member OSMa and AMA.

JOHN HAROLD KING, MD, Mansfield; Case Western Reserve University School of Medicine, 1933; age 88; died June 17, 1993; member OSMa and AMA.

BENJAMIN LEHMANN, MD, Hamilton; Louisiana University School of Medicine, New Orleans, LA, 1939; age 88; died July 5, 1993;

member OSMa and AMA.

CONRAD T. RUSIN, MD, Lorain; Loyola University Stritch School of Medicine, Maywood, IL, 1941; age 77; died June 13, 1993; member OSMa and AMA.

KENNETH M. SMITH, MD, Middletown; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1935; age 86; died May 26, 1993; member OSMa and AMA.

JOHN PAUL URBAN, MD, Columbus; Ohio State University College of Medicine, 1935; age 82; died May 22, 1993; member OSMa and AMA. ■



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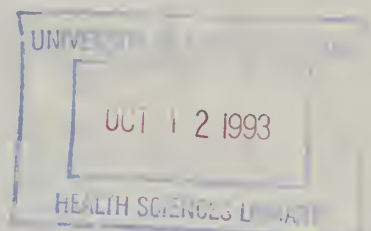
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OHIO *Medicine*



News for Members of the Ohio State Medical Association

OSMA unveils health reform plan

In Brief: The OSMA Task Force on Health-System Reform has developed, and Council has approved, recommendations for reforming Ohio's health-care delivery system.

The OSMA's Task Force on Health-System Reform, which has been meeting regularly since early April, has released its long-awaited recommendations for health-system reform here in Ohio. The OSMA Council approved the task force's recommendations at its September 18 meeting.

Walter Reiling, Jr., MD, president of the OSMA and chair of the task force, says he is pleased with the report. "Task force members spent countless hours looking through literally thousands of pages of materials on the health-care system in the process of developing its recommendations."

Dr. Reiling indicates that the task force worked diligently to balance individual perspectives. "Our reform proposals were not reached



Members of the OSMA Task Force on Health-Care Reform review the recommendations of the final report.

easily," says Dr. Reiling. "Task force members worked long and hard to put together a credible plan – one that we could all live with regardless of specialty, practice type or location. This report is a consensus – no one is 100% pleased

with each and every element of it. But we felt that we had to demonstrate that Ohio physicians were willing to do their part to help make health care more accessible

See **OSMA** page 3

OSMA responds to Clinton health proposal

Walter Reiling, Jr., MD, president of the OSMA, issued the following statement on President Clinton's health-care reform proposal:

"Ohio physicians share President Clinton's goal to reform the health system and provide essential health-care benefits to the people of this country. We

are particularly pleased with the emphasis he places on providing real health care instead of focusing on sick care. We know from working with our patients that preventing health problems can be one of the most effective methods of bringing down the cost of health care. All of us share the responsibility of helping build a system that delivers improved access, provides quality care and controls costs.

"It also is reassuring to hear recent comments about the importance of the patient being able to develop and maintain a relationship with a physician. That ability to choose, and the resulting trust in the patient/physician relationship, is critical.

"The upcoming debate on re-

See **CLINTON** page 3

Meetings on reform scheduled

The OSMA will be sponsoring a series of regional conferences to give members the opportunity to hear first-hand the recommendations of the Task Force on Health-System Reform.

Each member should have received an invitation to these meetings in late September. While the meetings are grouped by region for convenience, any member may attend any meeting free of charge. However, the OSMA is asking that members register for the meetings by using the registration card that was contained in a recent special mailing or by calling 1-(800) 766-OSMA and asking for the Department of Medical Society Relations.

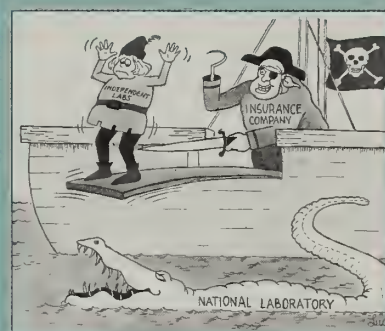
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Inside

■ **HMO BILLS:** Two bills would provide physicians with some protection from the capricious contracts of HMOs. **4**

■ **TORT REFORM BILL:** Sen. Cooper Snyder has introduced an omnibus tort reform package at the Statehouse. **4**

■ **NEVER-NEVER-LAND:** An Ohio physician takes a satirical look at how managed care will affect independent labs. **8**



A doctor's Never-Never Land

■ **MALPRACTICE CAP:** The Ohio Health Care Board is to recommend that noneconomic damage malpractice awards be capped at \$1 million. **12**

■ **DOCTORS GET A CHECK-UP:** Your patients may be examining you first, courtesy of a new company that provides clients with the good and bad news on Ohio physicians. **23**

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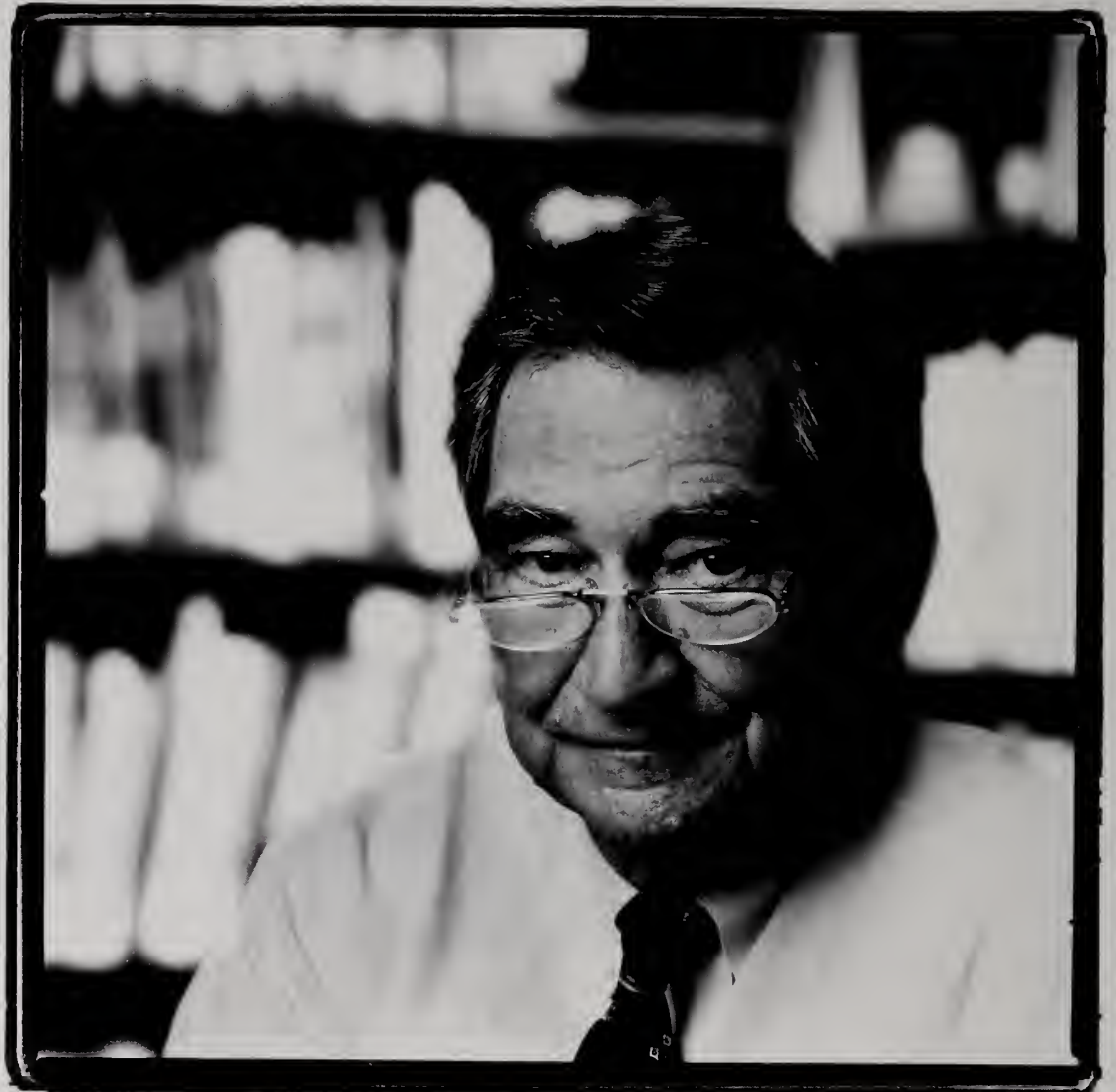
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and more affordable."

The report, which is called "Shared Goals, Shared Responsibilities: Changing Ohio's Health System," places special emphasis on each participant in health care – patients, hospitals, insurers and physicians – being more accountable for helping to contain costs. (See the related boxed story for plan specifics.)

OSMA members will have the opportunity to learn about the task force recommendations and other health-care reform proposals at one of a series of regional meetings the OSMA is sponsoring during the first three weeks of October (see story below for meeting specifics).

REGIONAL...*From page 1*

At each meeting hors d'oeuvres and soft drinks will be available from 6:30 p.m. to 7 p.m. The program will begin at 7 p.m. and adjourn no later than 9 p.m.

REGIONAL MEETINGS

Wednesday, October 6

Parke Hotel, Belden Village, North Canton

Wednesday, October 6

Westbrook Country Club, Mansfield

Tuesday, October 12

Holiday Inn, Worthington

Wednesday, October 13

Ohio University Inn, Athens

Wednesday, October 13

Holiday Inn, Lima

Wednesday, October 20

Holiday Inn-Southwyck, Toledo

Wednesday, October 20

Kings Island Inn & Conference Center, Kings Island

Thursday, October 21

Harley Hotel, Cleveland South, Cleveland ■

CLINTON...*From page 1*

forming the health system is going to be long and hard, but there can be no mistake that change will occur. A recent survey by the Ohio State Medical Association revealed that almost 90% of Ohio physicians believe that significant changes are needed. We look forward to working to bring about those changes with the needs of our patients as our primary focus." ■

The OSMA proposal joins other plans that have been or will be under consideration by the Ohio Health Care Board and the Ohio Legislature.

Dr. Reiling says, "As doctors, we have a unique perspective to offer policymakers as they attempt to develop a comprehensive health-care reform plan. After we have a chance to look at the details of the

Clinton proposal and the recommendations that are being developed by the Ohio Health Care Board, we will translate the elements of our recommendations into a legislative policy and develop a strategy for communicating with the public and with Ohio legislators.

"Physicians can't remain silent as the world around us debates

health-care reform," Dr. Reiling says. "We must speak out for our patients and the profession. I urge members to attend these regional conferences so that they can learn more about the task force's report. Ohio physicians need to speak with one voice when we approach legislators and other policymakers on the issue of health-system reform." ■

SHARED GOALS SHARED RESPONSIBILITIES

CHANGING OHIO'S HEALTH SYSTEM

The following is an excerpt from the report of the OSMA Task Force on Health-System Reform.

The first priority of the task force was to assure that all Ohioans can receive essential health care. Central to achieving this is to mandate that all employers provide insurance for their workers, regardless if they are full- or part-time.

However, individuals would be brought back into the system more directly through increased use of copayments and deductibles, and financial incentives to avoid utilization of services that may not be necessary. System efficiencies must be put into place to make coverage affordable for small business and self-employed individuals. Changes recommended include reducing paperwork and unnecessary regulation, and providing tax incentives for the purchase of health insurance by self-employed persons. Limitations on pre-existing conditions would be prohibited, and community-rating and portability of coverage would be required.

A basic level of benefits is recommended to be offered to all persons in Ohio. These benefits would provide essential preventive services, such as prenatal, well-baby and well-child care, at no cost to patients and would make other necessary care, such as physicals and certain screenings, available at an affordable price. Limited mental health, substance abuse and home health services also would be covered.

Medicaid recipients would be mainstreamed into the private insurance market to broaden the health-care access of Ohio's poor and eliminate stigmas that may be attached to program recipients.

Health-system costs must be brought into control. The task force recommends a number of areas where physicians can and

should make a greater effort to reduce those costs over which they have control. The task force recommended modifying physician reimbursement practices and publicizing information that allows consumers to make cost comparisons among physicians or physician groups.

The task force supports the development of practice parameters that define sound standards of care for physicians and patients. Medically sound practice parameters could define quality care and assist physicians in determining treatment options. Greater emphasis on outcome evaluation research also will assure that treatments offered by physicians are proven effective.

The task force recommends a number of changes in the medical education system to increase the number of primary care physicians. A greater emphasis on primary and preventive care in many areas is needed. Health education and tangible incentives need to be strengthened to encourage Ohioans to make healthier lifestyle choices.

The task force strongly supported changing the medical malpractice system to maintain patients' rights while enabling physicians to concentrate on providing quality health care and removing the pressures that lead to the practice of defensive medicine. A number of specific reforms were suggested.

Complexities of the health system require that a coordinating body be created. The task force recommends a new, carefully constructed 15-person commission, made up of practicing physicians and other key persons. It would oversee reforms, define the essential benefits package, measure the

costs/benefits of various medical technologies, participate in the budget process and assure ongoing improvements in the health system.

The task force recommends acceptance of a rationally developed health-system budgeting process. All participants in the health system must be involved in the development process. The system may involve financial disincentives for those physicians who consistently exceed budget projections. It may also impose new limitations on physicians in the form of strong incentives to measure the cost-effectiveness of treatment decisions. The task force supports fiscally sound expenditure targets based on solid actuarial data, rather than rigid global budgets.

Financing of system reforms, specifically those increasing the availability of care, would come from a combination of employer payments, tax incentives, current Medicaid funds, surcharges on health insurance and taxes on products with adverse health effects.

Achieving real improvement in the system, and not simply cosmetic reform, will not be easy. Nothing will be gained unless everyone – physicians, insurers, citizens and lawmakers – recognizes that our expectations must be realistic. Continuing to conduct business as usual is an option for no one. Nor can we fool ourselves into believing that society can afford to give every possible health benefit to every single person. If a better health system is to be attained, then each of us must accept personal responsibility for improving it. ■

Legislators to study rural, primary care medicine

Two Ohio legislators are taking separate looks at recurring health-care delivery problems in the state.

State Rep. Wayne Jones (D-Cuyahoga Falls) will head a 14-member committee that has a two-fold purpose:

1. To encourage medical students to become primary care doctors rather than specialists.
2. To keep more Ohio-educated physicians from leaving the state to practice medicine.

The state budget bill, which passed this summer, contains a provision that uses a part of the increased physician licensure fee to fund a primary care physician loan-repayment program. This program will provide grants to primary care physicians who con-

tract to practice in underserved Ohio areas.

Also, a new, federally funded program, Ohio Education Linkage Program, overseen by the Ohio Department of Health, has begun

Medical students are being urged to consider primary care as a career.

to expose medical students to primary care practices, primarily in rural and other underserved areas, by letting them practice there for a certain period of time. But Rep.

Jones' committee will also examine other ways to entice students into primary care – for example, placing restrictions on medical licenses or providing financial incentives.

Among those sitting on the committee are Robert Blacklow, MD, president of the Northeastern Ohio Universities College of Medicine, and Sen. Grace Drake (R-Solon).

RURAL HEALTH

Meanwhile, State Rep. Doug White (R-Manchester) is working with the Ohio Department of Health (ODH) to organize the Rural Health Legislative Caucus.

The caucus would work with the ODH's Office of Rural Health to draft legislation that attempts to meet some of the 124 separate issues and concerns – identified

through recent regional rural health meetings – that are unique to physicians and patients in rural areas.

The precarious position of most rural hospitals, and the difficulties accessing primary medical care in rural areas, are two problems the caucus hopes to immediately address.

OHIO Medicine will keep you notified of developments on these committees as they occur. ■



Rep. Jones

Two bills seek to improve fairness of HMO practices

In Brief: Two bills, now in the Ohio House, would provide physicians some protection from the arbitrary contractual practices of some HMOs.

The issue of whom HMOs may choose to contract with and whom they may drop heated up again this past summer when one of central Ohio's largest managed-care networks, Physicians Health Plan (PHP), suddenly announced that it was dropping three Columbus hospitals from its network.

The move drew the attention of legislators who had already spent some time this year considering House Bill 28, a bill sponsored by Rep. Otto Beatty, Jr. (D-Columbus), which would prohibit HMOs and PPOs from discriminating against minority and women physicians.

That bill, however, has been stalled in a House subcommittee – although a portion of it was passed when the state budget bill was finally approved this summer. That section prohibits discrimination by any HMO that participates in the state's health-care plan.

STRONGER MEASURE NEEDED

When PHP dropped Ohio State University Hospitals, Park Medical

Center and Columbus Community Hospital with time still left on their contracts, one legislator was prompted to take further action.

Rep. Michael Stinziano (D-Columbus), who chairs the House Insurance Committee where HB 28

PHP recently unexpectedly dropped three hospitals from its network.

still resides, introduced his own bill, House Bill 469, following August hearings on the Columbus hospital situation. HB 469 establishes specific procedures that HMOs must follow to terminate contracts with providers.

Since the introduction of HB 469, PHP has announced that it will permit enrollees to continue to use the three Columbus hospitals for the remainder of their contracts.

Earlier this year, the OSMA had pushed for amendments to HB 28 that would compel HMOs that dis-

miss a physician, or fail to renew a physician contract, to give them reasons for doing so. Another OSMA-proposed amendment would force HMOs to offer physicians an opportunity for a fair hearing.

"As managed care gains a larger share of the marketplace, it's clear that OSMA will have to aggressively pursue new laws that assure that physicians will be protected against capricious and unfair contractual practices," says John Van Doorn, director of OSMA's Department of Legislation.

OSMA will work with legislators on both bills to see that such protections are put into place. Van Doorn says it is not yet clear which bill is likely to move to the Senate. The Ohio House may already have passed one or both of these bills by the time you read this. ■



Rep. Stinziano

Tort reform bill introduced

Sen. Cooper Snyder (R-Hillsboro) has just introduced a tort reform bill that includes many features that have been widely discussed in medical circles for years – statute of limitations on malpractice claims, caps on damages awarded, limiting attorneys' contingency fees, expert witness credentials, and collateral source rules.

"The OSMA has been working actively with Sen. Snyder on this bill," says Cynthia Snyder (no relation), associate director of OSMA's Department of Legislation. In addition to drafting the bill, Sen. Snyder has also formed a coalition made up of business, consumer and health-care groups to advocate its enactment.

It's still too early to say, however, how successful the bill could be – especially in view of any tort reform measures that may be presented by President Bill Clinton, or, closer to home, the Ohio Health Care Board.

"A bill such as this will need the commitment of leaders of both the Senate and the House, as well as the governor," says the OSMA's Snyder. "It's just too preliminary to know yet whether that commitment is there at this time." ■

Ohio data center to make report

By late next year, the state hopes to make available to the public:

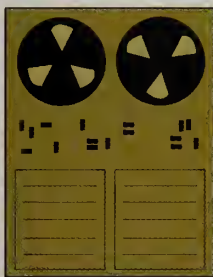
- Cost and quality comparisons of health-care providers
- The use-rates of high-tech equipment
- Emergency room and nursing home use
- Trends in pharmaceutical use
- The effects of defensive medicine on health costs

All those statistics, and more, will come compliments of the Ohio Health Care Data Center, which was established as part of House Bill 478, the state's year-old health-care reform measure.

The data center will be a massive electronic data interchange that will collect information from Medicare, Medicaid and other agencies that deliver health-care services. State officials will study the collected data to determine how they might cut – or at least control – escalating health-care costs.

"We're collecting information about what we're buying," said Peter Somani, MD, director of the Ohio Department of Health, in recent news reports. "We're going to start looking at costs and outcomes to find out why we're paying so much in some areas and less in others."

Although Ohio hospitals and physicians already submit data to such agencies, the information has not been kept in an organized fashion. That will be the job of the new Ohio Health Care Data Center, and the state's new budget has allocated \$2.3 million to the center for that purpose. A new director has been named, and the center's first reports are expected by late 1994. Also collected by the new state data center will be figures on: availability and cost of care for employees of small businesses, administrative costs in public vs. private sectors, and the effects of risky behavior on health costs. ■



More limited practitioners seeking licenses

Nurses and physician assistants are no longer the only allied practitioners hoping to expand their scope of practice in Ohio.

Over the past few months, a number of new bills have been

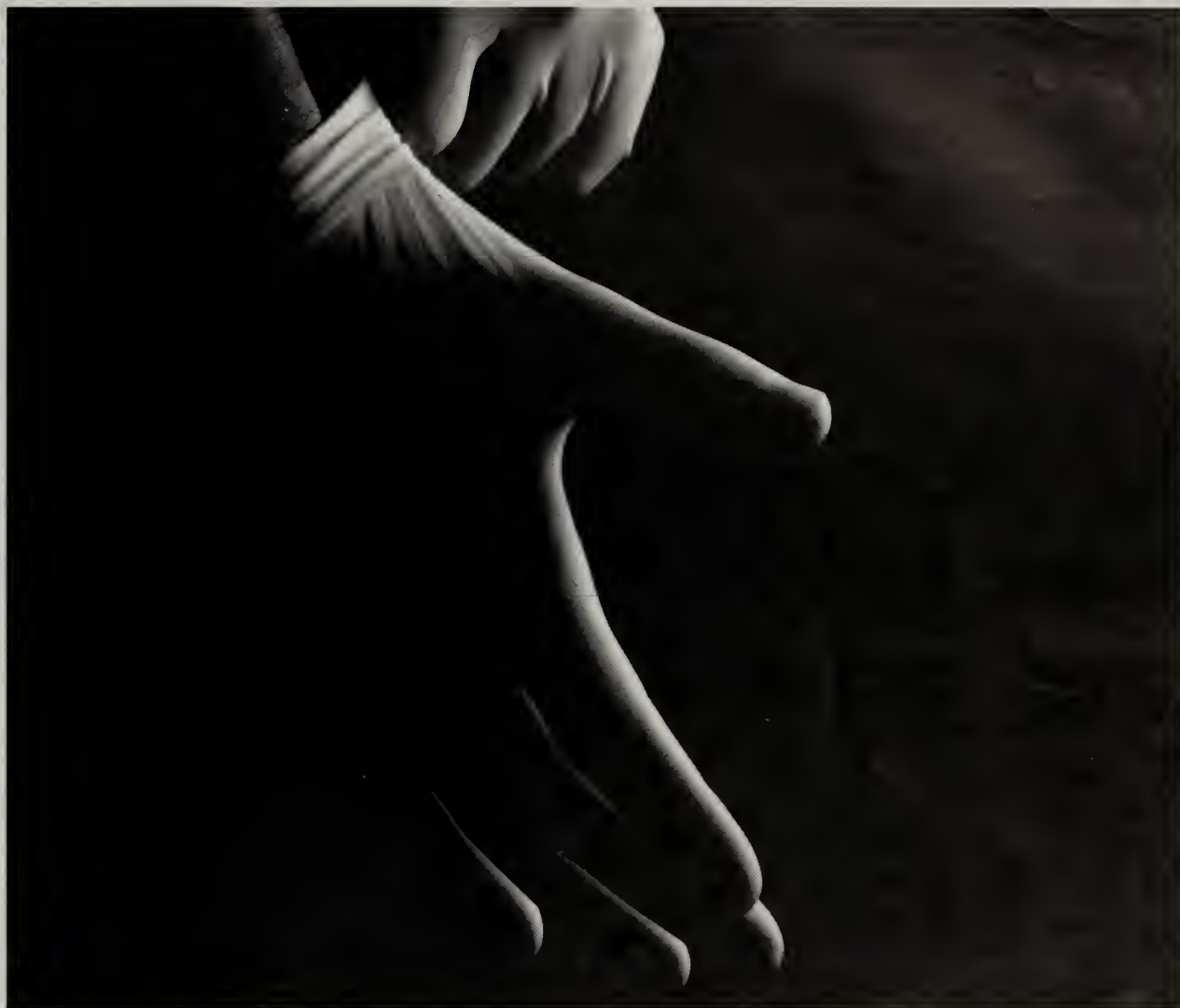
introduced that would license a wide spectrum of health-care providers:

- House Bill 451, introduced by Rep. Paul Jones (D-Ravenna),

would license recreational therapists.

- House Bill 461, also introduced by Rep. Jones, would license

Continued on next page



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marital and family therapists.

- Senate Bill 191, introduced by Sen. Grace Drake (R-Solon), would license radiation technologists.
- Senate Bill 194, introduced by Sen. Alan Zaleski (D-Vermilion), would license clinical labs and lab technicians. (A provision in federal CLIA regulations allows states to assume oversight responsibility for in-state clinical labs.)

Meanwhile, the OSMA continues to meet with representatives of the Ohio Nurses Association in an attempt to work out a compromise on legislation that expands the nurses' scope of practice.

"We're making progress," notes John Van Doorn, OSMA's director of Department of Legislation. ■

If you have questions about any story in the Legislation section, contact the OSMA Department of Legislation at 1-(800) 766-OSMA.

Two laws become effective this month

Two bills affecting medicine go into effect as law this month.

The first law requires every nursing home applicant in Ohio to undergo an evaluation to determine the extent of their illness and whether or not they might be better served outside of a nursing home.

The law is an attempt by the state to reduce the number of patients entering nursing homes, as well as

an effort to weed out patients who don't belong there.

Even patients who pay their own way may be discharged against their will under the new law if they enter against the advice of the state's social workers and later try to use Medicaid to pay their bills.

Under the second law, managed health care comes to the Bureau of Workers' Compensation system as

House Bill 107 goes into effect.

Under the reform package, the bureau is to set up a managed-care system for 250,000+ employers covered by the state system. Within six months, self-insured companies and private employers who form groups are to establish managed-care systems. ■

CON law expected to be extended

Ohio's certificate-of-need law, due to expire next month, will most likely be extended for another year.

Lawmakers, faced with a November deadline, believe they have neither the time nor the opportunity to receive and consider a report from an advisory committee, chaired by Sen. Grace Drake (R-Solon). The committee was considering whether or not the law should remain in its present form. Also in question was wheth-

er or not there would be time for the advisory committee's report to be considered by the Ohio Health Care Board which, in turn, would present recommendations to legislators.

Consequently, in late August Sen. Drake introduced Senate Bill 201, which seeks to extend the present law through next year.

"I think it's clear the lawmakers will extend the existing law and return next year for significant

reform," says John Van Doorn, director of OSMA's Department of Legislation.

Although it's unclear what "significant reform" will ultimately mean to Ohio physicians, Van Doorn predicts that a future CON law will probably feature a more rigorous review process, one in which more services, in addition to capital expenditures, will be looked at. ■

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PRESIDENT'S PERSPECTIVES

Health-care reform – the bottom line

As I review the numerous health-care reform proposals, I am struck not by their individual uniqueness but rather by their similarity, their sameness. As an example, the Republican Party recently released a health-care plan that virtually mirrors the anticipated Clinton proposal. There seems to be evolving a national consensus regarding the elements necessary to address the problems of our health system.

Who can argue with universal access for necessary health care, basic health insurance and assured affordability, portability and community rating for health insurance? Who wishes to debate the need for cost-containment, malpractice reforms, quality outcome studies and increasing the number of primary care physicians?

As virtually all reform packages share the same reform elements, they also share, in my judgment, the same serious flaw! They fail to adequately address reasonable and credible methods for funding the inevitable additional costs inherent in providing additional coverage.

I am personally convinced economic issues will ultimately be the central focus of the health-care debate. This is unfortunate, for important health issues will likely be decided solely by monetary considerations.

Granted, the economics of health care is an extremely complex subject, yet after several years of study there is no agreement as to the additional cost in providing universal access. Two totally diverse schools of thought are emerging. The first relies on a simple mathematical model, which goes something like this: Currently we are a country of approximately 250 million people, 30+ million of whom do not have health insurance. We currently spend about \$800 billion yearly on health care. Therefore, we must anticipate a 12%-15% increase (+\$100 billion) to cover increased coverage. We can, however, reduce that amount by 20% to allow for health costs not usually covered by insurance.

Unfortunately, the above pre-assumptions suffer from a serious

and erroneous assumption. All physicians know that most, if not all, "uninsured" patients already receive necessary care. Their costs are simply shifted to those who are insured.

Enter now the second school of thought, which simply states: "There is already enough money in the system to cover all Americans. No increased funding is necessary." As a point of more than passing interest, I understand several influential members of Gov. George Voinovich's Ohio Health Care Board seem to favor this viewpoint.

Actually, it should be apparent that the funding needs to be somewhere between these two extremes, but exactly where is anybody's guess. Reform requiring excess funding would be politically unpalatable and guarantee almost certain severe rationing. Underfunding, on the other hand, requires providers to accept an undue burden, creating an even

Walter A. Reiling, Jr., MD



more pronounced access problem.

Assuming agreement can be reached as to the degree of additional funding, we still need to decide how to raise the additional revenue.

Certainly the popular sin taxes cannot ever hope to generate that amount of income. Income and sales tax increases of that magnitude would incite riot. Most favor increased employer contributions, but small business strenuously objects.

I think it is time we find out what the public is willing and able to pay and design our system around a realistic budget. ■

ALLIANCE REPORT

Do you get your money's worth? You bet!

No matter what organization you pay dues to, you have probably asked yourself if you are getting your money's worth. I can assuredly say that for membership in the Ohio State Medical Association Alliance and the American Medical Association Alliance, YOU BET!

The OSMA-A provides leadership training and educational focus programs relating to health programs throughout the year. One of our most successful endeavors has been providing legislative information and encouraging grassroots involvement. Our sponsored day, "Communicating at the Capitol," has always been well-attended and appreciated by both our members and our Ohio legislators. Our involvement in the political process can make a differ-

ence regarding health issues.

Twice a year, the AMA-A helps sponsor 20 county presidents-elect from Ohio to attend a leadership confluence in Chicago. For three busy days, the members are guided through leadership training seminars featuring topics on violence, drug use and abuse, working with the media, motivating volunteers, membership involvement and, yes, national legislative information.

Alliance members return home loaded with printed material to assist them in their leadership year, knowledge on the numerous health programs sponsored by the AMA, and legislative expertise on the importance of being involved at the county, state and national levels. A unanimous response from all attendees has been the appreciation

of personal contact with national leaders, making friends from all across this nation, and sharing concerns with other physicians' spouses.

Nationally acclaimed experts and speakers are engaged to present the various programs. These people usually do not come cheap. Every member's dues helps sponsor these confluences and programs. Members that are unable to give of their personal time help their fellow members with their dues. This enables us to sponsor these training seminars and health programs in our communities.

Is it worth it to join? You bet it is. We have not yet received a nega-

Valerie Vollmer, President



tive evaluation from our members that have attended. They return home well-informed and enthusiastic regarding their year of leadership, during which they will help to promote health care, healthy lifestyles and their physician spouse's concerns.

Won't you ask your spouse to join us? ■

SECOND OPINION

"Any willing provider" in Never-Never Land

By Robert T. Brodell, MD, FAAD, FASD

The Cast

Peter Pan – Myself

Shipmates – Local physicians who refer to my lab

The Children – Insured patients

The Pirates – A large national laboratory

Captain Hook – The medical director of a large insurance company

Never-Never Land – Northeastern Ohio

Once upon a time, a few days ago, I received a certified letter from a major insurance company that noted that my independent certified skin pathology laboratory and all other local laboratories were being terminated from the panel of providers for this company in 60 days. We were being replaced by a national laboratory that would be providing all laboratory services for insured patients. I had heard of

these things happening in strange far-away places, such as California, but believed that I was immune from such occurrences in the heartland of America, Never-Never Land. The following conversation occurred within hours of my notification:

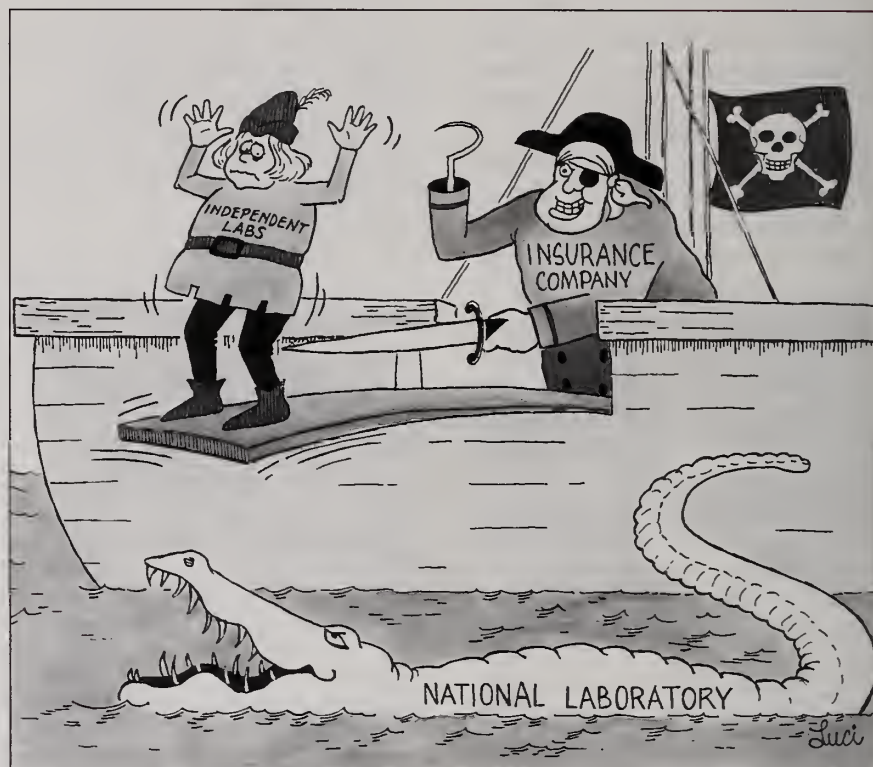
Peter Pan: This is making me grow up quickly! What have I done to deserve being terminated?

Captain Hook: You have performed well for eight years, but we negotiated a contract with the pirates for all laboratory services for which we will save thousands of dollars for our children.

Peter Pan: But I was never contacted about the price of my lab services! I am sure they are competitive with all the laboratories in this area. In any event, I would be glad to meet whatever price the pirates gave you.

Captain Hook: Sorry, it's too late. You should just fly away.

Peter Pan: Have you contacted my shipmates? They send specimens to



my lab because we give them excellent service with a pick-up service for specimens, complete reports including microscopic descriptions, 48-hour turnaround time, phone consultations, and, most importantly, we know each other's habits. Communication is the key to good dermatopathology.

Captain Hook: The pirates have assured us that they will offer quality service.

Peter Pan: Is there anything that I can do to appeal this decision?

Captain Hook: No.

Peter Pan: Is there anything my shipmates can do to appeal this decision?

Captain Hook: No, unless they want to walk the plank with you and not take care of our children.

Peter Pan: Is there anything my children can do to appeal this decision?

Captain Hook: No.

Unfortunately, this is not a fairy tale. There are at least two things that can be done.

First, legislation can be written to

require managed care plans to contract with any provider willing to meet the terms of the contract ("Any Willing Provider" laws). Fifteen states have such laws. My state does not! These are pro-competition laws. I was not given the opportunity to compete in the above scenario. All physicians are at risk without such a law.

Secondly, hospitals and physicians can legally form HPOs (Hospital-Physician Organizations). These groups can defend local physician and hospital interests. They provide a balance to the power of managed care plans. We are investigating the formation of such a group at our local hospital, but only wish this had been done months ago. This organization would have the power to negotiate on behalf of an individual in the group.

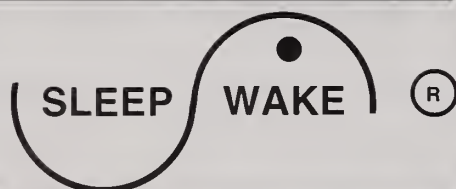
If physicians are to be able to live in a world of happy endings, it is important to start on these initiatives before they involve you personally. ■

Dr. Brodell is a Warren dermatologist.

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Helmut S. Schmidt, MD, ABPN, ABSM
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LETTERS TO THE EDITOR

Doctor, CMIC disagree over "fair reimbursement"

To the Editor:

As a rural family physician who has an active obstetric practice, I have my own opinion as to the reasons for Community Mutual Insurance Company's decision to reduce the reimbursement to obstetricians performing c-sections. As a former preferred provider for CMIC, I was given "fair reimbursement" for nine months of prenatal care to one of my patients as well as management of labor, making the medical decision to have a c-section performed, assisting in the emergency c-section, as well as providing care of the child that was born. This "fair reimbursement" was \$515. Even on appeal, this reimbursement was not changed significantly. Needless to say, I terminated my relationship with CMIC at that moment.

I believe that CMIC's primary motive for changing their reimbursement to obstetricians for c-section is strictly to decrease the reimbursement to physicians in general. If they truly wanted to encourage vaginal deliveries over c-sections, they would take the money that they were saving by not paying increased physicians' fees for c-section, and use that money to increase the reimbursement for vaginal deliveries. This does not seem to have been part of their plan, however. If CMIC is one of the "physician-friendly" insurance companies, God help us! I would rather work under a unified health-care system than continue to deal with insurance companies that have policies such as this.

GREGORY BERGMAN, MD
Minster

OSMA commended for standing up to HB 215

To the Editor:

Congratulations to the OSMA on its adamant lobbying against HB 215, which would require physicians to inform their patients of their right to receive reports on their mammograms. What do they think doctors have been doing with X-ray reports over the past hundreds of years?

It seems that politicians have reached the bottom of the common-sense barrel and that the bottom, in fact, has just dropped out. The contents of the bill, as reported in *OHIO Medicine*, are positively incredible, and an insult to common sense, let alone medical ethics and doctor-patient relations.

Then again, why limit it to X-ray reports? Perhaps the legislators might think it a good idea to pass a bill for every study that is conducted on a patient, and that each bill would address the particular study, such as urinalysis, complete blood count, BUN, platelet count, creatinine, PSA – ad infinitum. Of course, all of us know that I presume HIV would be exempt from this.

There are legislatures that are in session only 60 days per year. If Ohio were one of these, Ohioans should benefit constitutionally, medically, financially and politically.

Keep up the superb work.

N.M. CAMARDESE, MD
President, Freedom in Medicine Foundation
Norwalk

New "danger hours" for sunbathers

To the Editor:

Physicians generally advise that sun exposure be avoided, if possible, between 10 a.m. and 2 p.m. It is widely assumed that these are the hours when ultraviolet B radiation (UVB) levels are the highest. I have recently

begun monitoring ultraviolet B levels in Cincinnati. My early results indicate that we, as physicians, may be giving inaccurate advice.

Ultraviolet B radiation was measured with a Solar light UV-Biometer at 30-minute intervals from June 18-July 18, 1993 on 20 cloudless days. The meter measures the amount of ultraviolet radiation in minimal erythema doses/hour for type 2 (average white) skin. The number of minimal erythemic doses per hour were added for each hour, and averaged for the 30-day period. The results were as follows:

| | |
|--------------------|---------------|
| 10 a.m. to 11 a.m. | – 1.30 MED/HR |
| 11 a.m. to 12 noon | – 2.18 MED/HR |
| 12 noon to 1 p.m. | – 2.74 MED/HR |
| 1 p.m. to 2 p.m. | – 3.26 MED/HR |
| 2 p.m. to 3 p.m. | – 3.20 MED/HR |
| 3 p.m. to 4 p.m. | – 2.86 MED/HR |
| 4 p.m. to 5 p.m. | – 2.01 MED/HR |
| 5 p.m. to 6 p.m. | – 1.54 MED/HR |

Measurements were consistent day to day over the 30-day span, and the low readings in the 10 a.m. to 11 a.m. interval cannot be blamed, for example, on a series of cloudy mornings. Lower readings in the morning may be due to the use of daylight saving time.

It's apparent from the average readings that we should be advising our patients to avoid the sun much later in the day than we currently do. The amount of UVB from 2 p.m. to 3 p.m. is the second highest amount per hour in the day, and the amount of UVB from 3 p.m. to 4 p.m., the third highest. Even the interval from 4 p.m. to 5 p.m. will sunburn an untanned patient with average white skin in less than 30 minutes.

Perhaps we should tell patients and the public to avoid the sun from 10 a.m. to 6 p.m., or at least to continue to use sunscreens and other UVB avoidance measures until 6 p.m.

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Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, Ohio High School Athletic Association, Ohio Athletic Trainers Association

The 1993 revised edition of "Role and Responsibilities of the Team Physician" is now available free of charge from the OSMA Joint Advisory Committee on Sports Medicine, the Ohio High School Athletic Association

and the Ohio Athletic Trainers Association.

The 42-page booklet serves as an aid to physicians providing medical coverage for youth, interscholastic, intercollegiate and adult sports events.

For copies, contact Sports Medicine, c/o Ohio State Medical Association, 1500 Lake Shore Drive, Columbus, OH 43204-3824 or call 1-(800) 766-OSMA. ■

Fax Alert offered to members



The OSMA released its first issue of a new fax newsletter, *Member Alert*, immediately after President Clinton announced his health-

system reform plan to a joint session of Congress last month.

This free newsletter was designed to provide members with up-to-the-minute information

about legislation and reimbursement issues, and other late-breaking news of interest to Ohio physicians. The newsletter will augment the information found in *OHIO Medicine*; it will not replace it.

Physicians may still sign up to receive *Member Alert* by faxing the form that will appear in next month's issue of *OHIO Medicine*. To participate, you must have a dedicated fax line. Because of the volume of calls, we will be unable to call individual offices before sending the fax newsletter. ■

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CALENDAR

The OSMA, in association with Conomikes and Associates, Inc., has planned the following practice management workshops for 1993.

Maximizing Your Collection Results

This one-day course is designed for the experienced office manager, billing supervisor and physician manager. The course deals with all aspects of the collection process. Learn to identify the problem, correct it and make certain it doesn't return. The workshop approaches the collections function from the management perspective.

- Oct. 12 Dana Center at MCO/Hilton, Toledo
- Oct. 13 Sheraton City Center, Cleveland
- Oct. 14 Parke Hotel, Canton
- Oct. 26 Concourse Hotel, Columbus
- Oct. 27 Stouffers, Dayton
- Oct. 28 Sheraton, Springdale, Cincinnati

Managed Care

Preparing for the Clinton Health Plan

This one-day course will show physicians and their office staff how to reorganize their medical practice under health reform, how to track results under managed care, how to evaluate contracts, how to maximize collections, and how to deal with gatekeepers.

- Nov. 2 Dana Center at MCO/Hilton, Toledo
- Nov. 3 Parke Hotel, Canton
- Nov. 4 Sheraton City Center, Cleveland
- Nov. 16 Concourse Hotel, Columbus
- Nov. 17 Holiday Inn/I-675, Fairborn
- Nov. 18 Kings Island Inn, Cincinnati

The following are sponsored in cooperation with the AMA's Financing and Practice Services, Inc., and the AMA Investment Advisers, Inc.

Gearing Up For Retirement

- Nov. 9, 10 Columbus Hilton North, Worthington

This workshop covers all sides of retirement - professional, personal and financial. It focuses on short-term financial planning to maintain your lifestyle through retirement, how to cope with inflation, how to measure assets and financial needs, and tax and estate planning.

Starting To Practice Smart

- Nov. 10, 11 Columbus Hilton North, Worthington

Joining A Partnership or a Group Practice

- Nov. 12 Columbus Hilton North, Worthington

These two workshops, aimed especially at residents and young physicians, will show physicians how to take care of business while they take care of patients. The seminars will focus on the pros and cons of group practice, how to value a practice, the costs of practice, how to track receivables and payables, and how to choose accountants, lawyers and other advisers.

JUA processing SRF refund claims

The Joint Underwriting Authority (JUA), the entity undertaking the refund of the remaining money in the Stabilization Reserve Fund, reports that it has substantially completed the initial notification of SRF contributors, and now is in the process of handling the thousands of Proofs of Claim filed by Ohio physicians and hospitals.

To date, the JUA has mailed 15,750 certified letters to physicians and hospitals for which contributions have been recorded in SRF records. Prior to this mailing, the

Claim. Approximately 7,800 Proofs of Claim have been forwarded to the Superintendent of Insurance for acceptance. The JUA has also taken over 1,300 telephone calls concerning the proper completion of the

Proof of Claim with the Superintendent of Insurance.

The deadline for filing an SRF Proof of Claim is November 12, 1993. Any claim that is not presented by then is forever barred. The submission of a Proof of Claim is the only way to become eligible to receive a refund from the SRF.

Note that only one Proof of Claim should be submitted per hospital or physician. Accordingly, if you have previously filed a Proof of Claim, you may ignore this warning.

Questions concerning the refund process should be directed to the SRF at (614) 888-8901. ■

The deadline for filing a Proof of Claim is November 12.

JUA was able to update the addresses contained in the SRF records with the assistance of the OSMA, Department of Insurance, Ohio Hospital Association, Ohio Osteopathic Association and Ohio Podiatric Medical Association. The initial notification process also included placing an announcement of the refund in a newspaper in each of Ohio's 88 counties.

In response to the contributor notification letters and the newspaper announcement, many potential claimants quickly returned an appropriately completed Proof of

OSMA waiting on reply from HCFA

The OSMA is still waiting on a response from the Health Care Financing Administration (HCFA) regarding implementation of a statewide fee schedule for Medicare.

In July, HCFA said it would reconsider adopting a statewide fee schedule if enough Ohio physicians wrote in support of it. The deadline for submitting letters was Sept. 13.

If the new schedule is accepted, it is expected to be implemented by Jan. 1. ■

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Ohio health-care board makes tort reform a priority

The Ohio Health Care Board has accepted a recommendation to cap noneconomic damages resulting from medical malpractice awards at \$1 million. The recommendation came from the board's malpractice reform subcommittee at its meeting last month.

The cap is unique, say board members, in that it is an advisory, not an absolute, cap. That is, if a plaintiff is awarded more than \$1 million, it is up to the plaintiff's attorney to convince the judge that the excess amount is justified.

Coincidentally, Sen. H. Cooper Snyder (R-Hillsboro) is also working on a tort reform proposal that will also include a cap on noneconomic damages in malpractice awards, but whether the board will

work with Sen. Snyder has yet to be decided.

According to board member Jack Burry, CEO of Blue Cross-Blue Shield of Ohio, the board is concerned that malpractice reform may be lost in an overall tort reform proposal. But, he adds, Sen. Snyder will receive a draft bill of the board's recommendations when it's completed, reportedly later this month.

Other recommendations the board accepted from the malpractice reform subcommittee include:

- Allow medical malpractice insurers to experience-rate physicians.
- Adopt federal rules that impose sanctions for frivolous

lawsuits.

- Divide compensatory and punitive damages in cases of admitted liability.
- Modify joint and several liability for noneconomic damages to a maximum of two times the percentage of negligence allocated to the defendant.
- Allow recovery of prejudgment interest from the date the cause of action accrued.

Claire Wolfe, MD, a physician representative on the board and OSMA's president-elect, calls the malpractice reform subcommittee's report "quite an exciting thing,"

and also notes that several other issues are under discussion:

- Limited immunity granted to physicians who treat indigent patients.
- Limited immunity for OB/GYNs who treat "drop-in" patients.
- Modifying the collateral source rule so that injured patients can't "double-dip," i.e., collect payment from multiple sources, such as disability and medical insurance, plus the malpractice economic settlement.

The board, which at press time was to hold an open hearing Sept. 21 in Dayton, is expected to deliver at least an outline for reform to Gov. George Voinovich by Jan. 1. ■

Colleagues

L. DAVIS ARBUCKLE JR., MD, Akron, was inducted into the Akron General Development Foundation's Society of Distinguished Physicians. Dr. Arbuckle chairs the Department of Urology and directs the residency program at Akron General Hospital.

PHIL B. FONTANAROSA, MD, Akron, was named a senior editor and department head at *JAMA*. Dr. Fontanarosa was research director for the department of emergency medicine at Akron City Hospital and associate professor of emergency medicine at NEOUCOM.

D. ROSS IRONS, MD, Bellevue, was elected president of the Ohio Chapter of the American College of Surgeons.

ROBERT A. KEMPER, MD, received the Special Recognition Award from the Cincinnati Association for the Blind. Dr. Kemper served as director of the association's low-vision service since 1963.

JAMES MAGISANO, MD, Rocky River, and **JOAN PALOMAKI, MD**, Bay Village, received Physician of the Year awards from Health Cleveland System. Dr. Magisano is a surgeon at Fairview General Hospital. Dr. Palomaki, also a surgeon, is with Lutheran Medical Center.

GEORGE W. PAULSON, MD, was named chief of staff at The Ohio State University Hospitals. Dr. Paulson is professor of neurology at OSU.

RICHARD ROLAND, MD, Youngstown, was appointed president of the professional staff of the Youngstown Hospital Association.

PETER SOMANI, MD, Columbus, was named a Distinguished International Medical Graduate by the American College of International Physicians. Dr. Somani is director of the Ohio Department of Health. He received his medical degree from Vikram University, Ujjain, India.

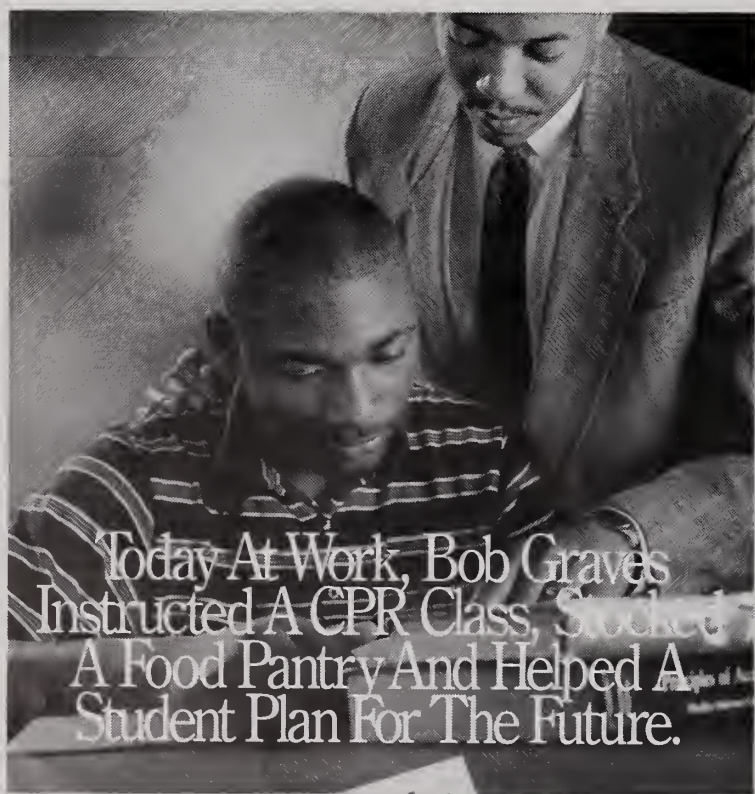
RAYMOND R. SUSKIND, MD, Cincinnati, received the Distinguished Alumni Achievement Award from the College of Medicine of the State University of New York. Dr. Suskind is director emeritus and professor emeritus in the University of Cincinnati's Department of Environmental Health. ■



Dr. Somani



Dr. Suskind



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HOPE IS IN YOUR HANDS

Membership focuses on women, IMGs

Focusing on the interests of particular groups may be the best way to increase membership. Doug Evans, director of the OSMA Department of Membership, says he has found that personalized letters to targeted groups yield a better response when seeking new members. Using this approach last year, 5.6% of the letters mailed to international medical graduates (IMGs) were returned requesting more information about joining OSMA, AMA and the county medical societies.

So, once again, special interest groups were targeted in this year's membership solicitation program. In September, personalized letters were mailed to more than 1,500 women physicians from OSMA President-Elect Claire V. Wolfe, MD, and some 1,700 letters were sent to nonmember IMGs from Woong S. Kim, MD, chair of the OSMA IMG Advisory Task Force. The membership department chose Drs. Wolfe and Kim to author the prospective member letters because of their active involvement in the association.

In Dr. Wolfe's letter, sent to nonmember women physicians in the state, she pointed out that as president-elect she is a visible presence

in the representation of female physicians within the federation of medicine. She believes the concerns of female physicians – issues of sexual harassment, gender disparity in research and access to high-

tech care, maternity leave and child care – should be addressed as organized medicine looks at issues facing all physicians. To ensure that the concerns of the women physicians are addressed, a short survey was included with the solicitation letter.

Dr. Kim asked for IMGs' support

in the continued fight against separate treatment of IMGs. He mentioned the successful work of the IMG task force in supporting HB 454 last year to ease licensure requirements for IMG physicians in Ohio and to phase out the Ohio State Medical Board's test of spoken English. ■

Workers' Comp contracts mailed

The Frank Gates Company mailed contracts to participants in the OSMA Workers' Compensation Group Rating Program in September.

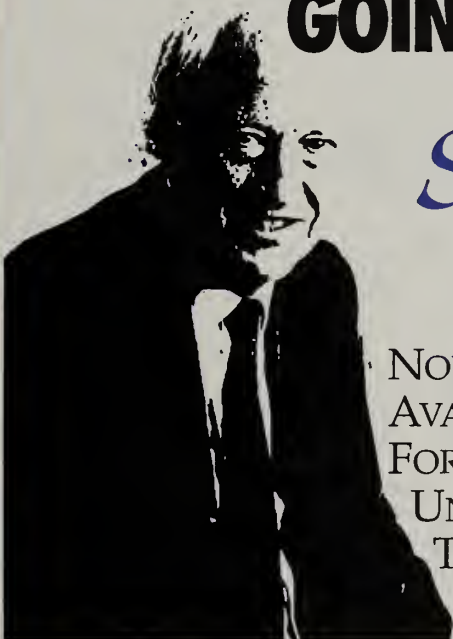
Contracts need to be signed and the service fee paid by November 15. Contracts should be returned to the Frank Gates Company.

It is anticipated that 1,700 medical offices will participate in the third year of the program, representing 5,100 OSMA members, with a gross savings to OSMA members of approximately \$2.3 million dollars.

If you have any questions, contact the Frank Gates Service Company, Client Service Department at 1-(800) 395-4119 or (614) 798-5500. ■

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County Notes

■ Cuyahoga County

Two new committees – the Committee on Academy Structure and the Advocacy Committee – are in the works at the Academy of Medicine of Cleveland.

The structure committee was developed to look at the relationship between the academy and its members and to figure out how the academy can be more responsive to important issues. The advocacy committee will identify issues in which the academy can assume leadership roles.

Also, the academy has initiated a new dues-paying policy. Physicians now have the convenience of paying dues in 12 installments without writing a check. Physicians' dues can be automatically withdrawn from his or her checking account, eliminating the need for an invoice. Others may opt for six monthly installments or using credit cards (Visa or Mastercard).

■ Franklin County

Members of the Academy of Columbus and Franklin County can expect to see a new directory, probably in January. The staff at the county medical society has been busy updating information and photographs of their 1,400 members. The academy's Joni Einarson says that the directory is usually updated every year, and new photographs are included every eight years. The directory is part of the membership package and will be mailed free to members in early 1994.

■ Hamilton County

Cincinnati physicians turned out in record numbers for the first midwest "Homeless Veterans Stand Down," sponsored by the Academy of Medicine of Cincinnati and held at Avoca Park in September.

Twenty-five primary care physicians armed with stethoscopes volunteered their services for homeless veterans and their families at the three-day event. Specialists in dermatology, orthopedic surgery and neurology also lent a hand. Supplies were provided by organizations throughout the Cincinnati area.

In addition to medical services, legal services, clothing, sleeping accommodations and showers were provided for the homeless. In conjunction with Women in Medicine month (in September) two free, brown-bag luncheon programs were offered by the academy's Women in Medicine Committee. Topics discussed were contraceptives and infertility.

■ Lucas County

If physicians in the Toledo area look slimmer and trimmer, it's probably because they're treating

themselves to exercise. Several members of the Academy of Medicine of Toledo and Lucas County are taking part in the "Doctor, Get in Shape" program.

According to Lynne Mangan, director of communications at the academy, the idea was the brainchild of the academy's president, John Robinson, MD, an avid exerciser.

Dr. Robinson and some of his board members started toting around a few extra pounds courtesy of the numerous banquets they had attended in the past year. They decided to do something about it. Four area recreation centers were contacted, and, as a result, began offering membership discounts to academy members. Dr. Robinson's goal is for academy members – as well as staff – to shed those few extra pounds by year's end. ■

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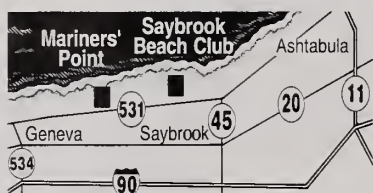
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Group practice program offered

What are some of the legal ramifications for group practices? How do you secure your group's financial stability? These and more questions will be answered in a one-day program designed for group practice physicians and senior administrators. The OSMA, along with the American Medical Association and the American Group Practice Association, have designed a timely, in-depth program to deal with these concerns. "Physician-Hospital Integration: A Group Practice Perspective" will be offered Nov. 12 from 9 a.m. to 4 p.m. at the Fawcett Center for Tomorrow in Columbus. Cost for members is \$50; nonmembers \$95.

The program will also include: group practice and vertical integration; integration in multiple-hospital and single-hospital communities; alternatives to securing your group's financial stability; and the nuts and bolts of integration.

For information or registration, contact Jill Foley, OSMA's assistant director for group practice membership, at 1-(800) 766-OSMA. ■

Jobs for "limited license" doctors in jeopardy

Foreign-trained doctors who practice in Ohio's state mental hospitals under a one-year "limited registration" arrangement with the State Medical Board may be in danger of losing their jobs once the switch to a single, standardized licensing test is made next year.

Because state mental hospitals have had a difficult time recruiting and keeping psychiatrists, Ohio has, for decades, allowed foreign-trained doctors without licenses to

exam. They predict that those psychiatrists who remain in the state system will be forced to do "first aid" on patients, rather than provide in-depth patient care.

There has been some movement

toward recruiting more American psychiatrists to work in state-operated facilities, but keeping them there is another matter.

ODMH's committee on psychiatric recruitment and retention

reported last year that salaries must be made higher if that goal is to be accomplished. ■

Information for this story came from the Dayton Daily News.

Foreign-trained doctors' jobs are especially likely to be in danger.

practice – but only in state mental hospitals. And since the state has never restricted the number of times these doctors can apply for limited restrictions, a number of unlicensed, foreign-trained doctors have been attracted to the state to practice, says a report issued last year by the Ohio Department of Mental Health (ODMH).

Next year, however, even doctors with limited registration will have to pass the new, standardized, three-part United States Medical Licensing Examination (USMLE) if they want to practice medicine in Ohio – or anywhere else in the country, for that matter.

Currently, foreign-trained doctors make up 85% of the ODMH's full-time psychiatrists, however only 19 doctors statewide hold limited registrations, and they have had their ODMH positions jeopardized because of changes in the standards for physician licensing.

The new USMLE test has proven tougher on IMGs than the Federation Licensing Examination (FLEX), which was administered to foreign-trained doctors up until this summer. According to the medical examiners board, only 35% of foreign doctors passed the toughest part of the USMLE in 1992.

Mental health officials are now concerned that a "mental health crisis" of sorts will loom in the state if these "limited license" physicians fail to pass the new, tougher

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Prescribing drugs: A look at 5 disciplinary cases

By Anand G. Garg, MD, and Joan Wehrle

Editor's note: In August, *OHIO Medicine* reprinted part of an article that appeared originally in the *Mahoning County Bulletin*. Co-authored by Anand G. Garg, MD, Youngstown, a member of the Ohio State Medical Board (OSMB), and Joan Wehrle, the OSMB's public inquiries officer, the article reviewed the statutes and rules regarding prescribing drugs in Ohio.

This month, several disciplinary actions relating to prescribing are examined. The original article looked at 22 cases. We've selected five to present here.

Disciplinary actions

In 1992, the Ohio State Medical Board took 100 formal disciplinary actions against physicians licensed by the board. Twenty-two of the actions were based either on drug-related criminal violations or inappropriate prescribing of controlled substances.

Listed below are the age, gender and specialty of each licensee subjected to action related to controlled substances. The disciplinary action taken by the medical board and the basis for that action are

also listed.

Case #1 – 58-year-old male, family practitioner

Violation: Excessive and improper prescribing of controlled substances; violation of medical board rules governing prescribing of controlled substance for weight loss.

Board action: Stayed revocation, indefinite suspension; conditions for reinstatement; subsequent five-year probation.

Case #2 – 58-year-old male, psychiatrist

Violation: Improper prescribing of controlled substances to two patients, despite doctor's awareness of their past problems with addiction and alcoholism.

Board action: Stayed revocation, indefinite suspension, minimum one year, conditions for reinstatement; subsequent probation for minimum of four years.

Case #3 – 48-year-old male, family practitioner

Violation: Prescribing controlled substances to his wife for seven

| Misused Substances | | |
|--|-----------|------------|
| A review of the drug-related formal disciplinary actions taken by the Ohio State Medical Board during 1992 indicated that the controlled substances listed below were misused: | | |
| Adipex-P | Hycodan | Talwin |
| Amitriptyline | Ionamin | Tranxene |
| Ativan | Limbitrol | Tussionex |
| Dalmane | Lomotil | Tylenol #3 |
| Darvocet-N | Oxocodone | Tylox |
| Demerol | Pamelor | Valium |
| Dilaudid | Percocet | Vicodin |
| Fastin | Placidyl | Xanax |
| Halcion | Restoril | |

years for treatment of headaches and pain following surgery; doctor prohibited from prescribing controlled substances to wife or any other family member.

Board action: Consent agreement, probation for minimum of two years.

Case #4 – 63-year-old male, internal medicine specialist

Violation: Found guilty of second-degree misdemeanor (illegal dispensing of drug samples).

Board action: Reprimanded, doctor required to notify all employers

and chiefs of staff of consent agreement/reprimand.

Case #5 – 66-year-old male, family practitioner

Violation: Misdemeanor conviction for improper disposal of controlled substances and adulterated drugs.

Board action: Indefinite suspension for minimum of 60 days, conditions for reinstatement, including requirement that doctor pass competence examination; subsequent probation for minimum of five years. Consent agreement. ■

Legal Notes

In Brief: This column is condensed from the OSMA's legal fact sheet notebook. You may want to clip and save this column for reference. Questions should be referred to the OSMA's Department of Legal Services.

Medical Records and the Rights of Divorced or Separated Parents

When parents divorce or separate, the physician often faces the difficulty of determining which parent is the decision-maker and what rights the other parent has when making medical decisions on behalf of their child. Under Ohio Revised Code section 3109.04, either parent or both may be given custody of the child, which includes the ability to make medical decisions for the child.

If one parent is given custody, that parent is designated the child's decision-maker, and the other parent becomes the non-

custodial parent and is usually granted visitation. If the parents are given joint custody, there must be a plan that spells out all parental rights and responsibilities concerning the care of the child, including the provision of medical care.

In the case of the noncustodial parent, certain rights are granted in addition to visitation, including the right to access any record related to the child, which may be maintained by hospitals or other facilities, or health-care professionals providing medical or surgical care.

If a court determines that it would not be in the best interests of the child for the noncustodial parent to have unlimited access to the child's records, the court must specify in a court order the terms and conditions of that parent's access. In the absence of such an order, the noncustodial parent is to be given the same access as the custodial parent.

A physician may be in contempt of court if he or she fails to give access to the noncustodial parent or fails to follow the court order limiting access. If the physician is found in contempt, he or

she may be ordered to pay any or all of the following: a penalty, court costs for the hearing on the issue of contempt, and any reasonable attorney fees of the adversely affected party.

The physician should, upon accepting the child as a patient, clarify with the parent who has legal custody of the child and who is legally responsible for making decisions about the child's medical care. Also, the physician should give both parents access to the child's records unless presented with a court order stating otherwise. ■

Federal self-referral ban expands to include Medicaid

In Brief: OBRA '93 previously banned physicians only from self-referring Medicare patients.

On August 11, President Clinton signed into law the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). One of the most significant provisions of this act for physicians and hospitals engaged in joint ventures with physicians is the broad expansion of the physician self-referral ban, which previously applied only to referrals of

the prior self-referral ban, the law still contains several significant exceptions.

One major exception is a group practice with multiple practice locations, essentially a "clinic

without walls" organization.

Other exceptions to the ban include federally qualified HMOs and designated health services furnished in a rural area by an entity if substantially all designated

health services are provided for individuals living in the area.

In addition, in-office ancillary services furnished under a phy-

Continued on next page

One exception is a group practice with several locations, known as a 'clinic without walls.'

Medicare patients for clinical laboratory services.

As amended, the law now prohibits a physician from referring Medicare or Medicaid patients for "designated health services" to an entity in which the physician or immediate family member has a financial or ownership relationship. In addition to clinical laboratory services, these designated health services include:

- physical and occupational therapy services
- radiology or other diagnostic services
- radiation therapy services
- durable medical equipment
- parenteral and enteral nutrients, equipment and supplies
- home health services
- prosthetics, orthotics and prosthetic devices
- outpatient prescription drugs and
- inpatient and outpatient hospital services.

EXCEPTIONS MADE

Although the OBRA '93 changes represent a significant expansion of



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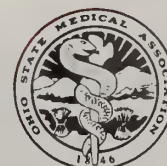
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sician's direct supervision are generally exempt from the ban. Two notable services that do not fit within this in-office exemption are durable medical equipment and parenteral and enteral nutrition equipment and supplies.

OBRA '93 also makes it clear that even if in-office services fit within

the designated exemption, there can be no direct compensation for referrals to the in-office designated health services. In addition, members of the group must personally conduct at least 75% of the patient encounters of the group's practice.

The statute painstakingly defines the necessary attributes for an

arrangement to fall within any given exception to the referral ban.

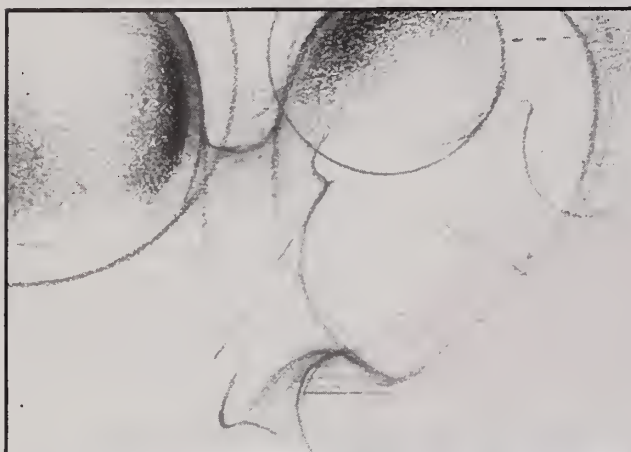
Accordingly, physician investments in, or business arrangements with, an entity that provides any of the designated health services should be carefully reviewed to determine whether the ban or any of its exceptions, apply to the spe-

cific facts.

This is particularly true in view of the fact that the penalties for making a prohibited referral or submitting a claim to any individual or entity for payment for services arising from such a referral, include civil monetary penalties and exclusion from the federal program.

If you have questions about OBRA '93, contact the OSMA's Department of Legal Services at 1-(800) 766-OSMA. ■

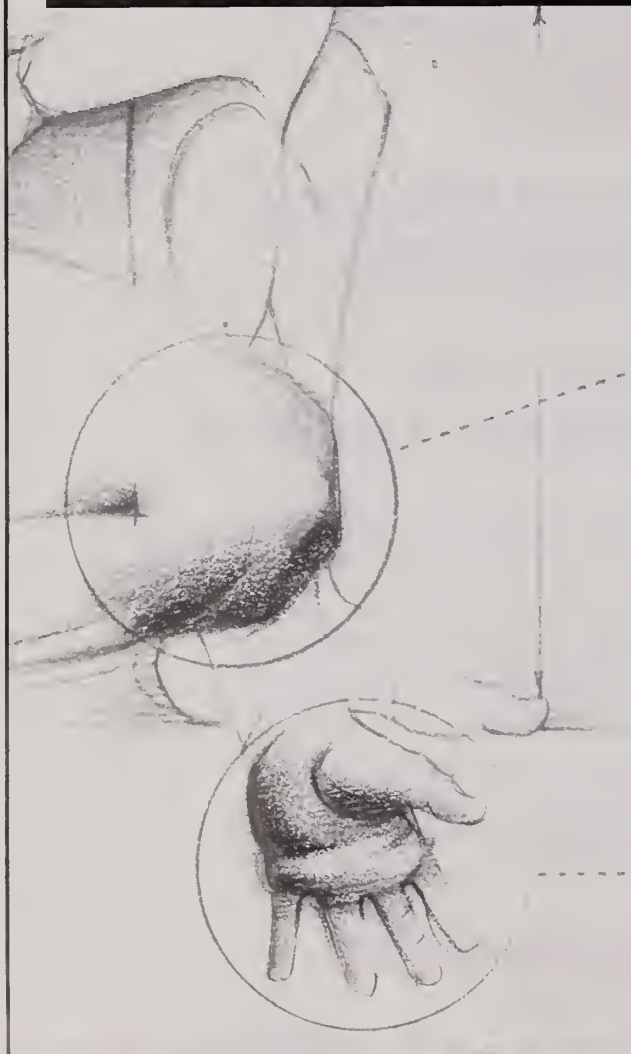
Information provided by William Todd and Terri Lynn Smiles of Squire, Sanders & Dempsey law firm.



Every field has its standard setter. And in evaluation of permanent impairments, the standard is the new *Guides to the Evaluation of Permanent Impairment, Fourth Edition*.

- *Guides* offers you a medically sound, standardized method to accurately evaluate and report permanent impairment.
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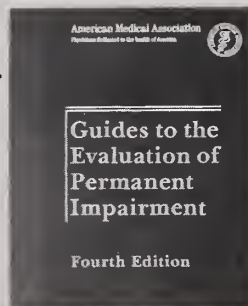


- *Guides* gives you an objective, uniform way to clearly communicate and compare your findings with others.
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Created with authorities from the major medical specialties and other experts, the new *Guides* will add an extra measure of credibility to your evaluations. *Guides* (Order #: OP025493KH) is \$40 for AMA members, \$60 for nonmembers.

The American Medical Association offers several other helpful, complementary books to *Guides*, too. They are *Occupational Low Back Pain: Assessment, Treatment and Prevention* (Order #: OP496093KH, \$79); *Thieme's Mobility: Theory and Practice* (Order #: OP999392KH, \$7.95); *Stretching and Strengthening Exercises* (Order #: OP993392KH, \$9.95); *Training Therapy: Prophylaxis and Rehabilitation, Second Revised Edition* (Order #: OP946493KH, \$25.95); and *Year Book of Occupational and Environmental Medicine* (Order #: OP946393KH, \$63.95).

To order, call 800 621-8335. VISA, MasterCard, American Express or Optima accepted. Shipping and handling charges apply.



American Medical Association

Physicians dedicated to the health of America



Family/medical leave forms now available

Family/Medical Leave Act (FMLA) forms, developed by the Department of Labor, are now available from the OSMA Department of Legal Services.

The August issue of *OHIO Medicine* reported on the Family/Medical Leave Act, which became effective August 5.

The act allows qualified employees up to 12 weeks of unpaid leave per year for the birth or adoption of a child, to care for a spouse, child or parent with a serious health condition, or when the employee is unable to work because of a serious health condition.

If covered by the FMLA, the employer must maintain any pre-existing health benefits during the leave period and must reinstate the employee in the same or equivalent position upon return.

Besides following the law in their own offices, physicians are responsible for filling out medical certifications that employers may require of their employees.

A statement of explanation must be included with the certification, detailing why the employee is unable to perform essential duties of his or her position, or if the leave is for a family member, the statement must explain why the patient needs help fulfilling basic needs.

To obtain a form, contact the OSMA Department of Legal Services at 1-(800) 766-OSMA. ■

Mammography bill clarified

There is still some confusion about Ohio's new mammography mandate law (House Bill 142) that is now in effect. To add to the confusion, *OHIO Medicine* mistakenly reported last month that: "Ohio's insurers are now required to cover screening mammograms."

In fact, HB 142 is not an *insurance* mandate law; it is an *employer*-mandated coverage law.

On page 3 of the enacted version of HB 142, paragraph (B) of the Ohio Revised Code 3923.5 says that every health insurer "shall offer to provide benefits for the expenses of both of the following: screening mammography and cytologic screening." This language does not require insurers to cover, only to offer coverage for, these two services.

However, on page 5 of the bill, paragraph (B) of ORC 3923.54 says that every employer "that provides, in whole or in part, health-care benefits for its employees" under health insurance or HMO coverage "shall also provide to its employees, benefits for the expenses of both of the following: screening mammography and cytologic screening."

This section goes on to say that employers may satisfy this requirement in any of the following ways:

1. Providing health insurance coverage or HMO coverage;
2. By reimbursing employees directly for the cost of these two services; or
3. By making any other arrangement that provides these benefits.

This means that employers are required to pay the cost of these two services for their employees, but employers have several options as to how they will comply. Thus, health insurers are not compelled to cover screening mammographies in their policies and may offer this coverage as a separate policy rider, which the employer may choose not to purchase for its employees.

If you have questions on the new law, please direct them to the OSMA Ombudsman office at 1-(800) 766-OSMA. ■

Durable medical equipment guidelines

Beginning November 1, 1993, Nationwide-Medicare will no longer process claims for durable medical equipment, prosthetics and supplies (DMEPOS).

The Health Care Financing Administration (HCFA) has entered into a contract with four Medicare carriers to perform all of the duties associated with processing claims for DMEPOS. It is necessary that all physicians who wish to receive reimbursement for DMEPOS who have not already done so register and apply for a new supplier number.

HCFA has contracted with the following carrier to distribute applications, verify the data, issue new supplier numbers and maintain a national DMEPOS supplier file:

National Supplier Clearinghouse
(NSC)
P.O. Box 100142
Columbia, SC 29202-3142

The NSC will not process or maintain information about claims. Physicians will need to file claims with one of the four regionalized DMEPOS carriers. The carrier to which physicians will file their claims is based upon the state in which the beneficiary maintains permanent residence. ■

Phase-In Schedule

| Effective Date With New Carrier | State Patient Resides In | DME Regional Carrier |
|------------------------------------|-----------------------------|---|
| November 1, 1993 | Ohio | Administar Federal Inc. |
| November 1, 1993 | West Virginia | P.O. Box 7078 |
| October 1, 1993 | Indiana | Indianapolis, IN 46207-7078 |
| December 1, 1993 | Michigan | (800) 346-2233 (8:30-3:30 EST) |
| January 1, 1994 | Pennsylvania | The Traveler's Insurance Co. Government Operations One Tower Square Hartford, CT 06183 |

Codes That Should Be Submitted to the DME Regional Carriers

| | | | |
|------------------------------|---|------------------------------|----------------------------|
| Dialysis Supplies | A4650-A4927 E1510-E1699 | Ostomy/ Miscellaneous | A4190-A4640 A5051-A5149 |
| Equipment | E0000-E0399 E0500-E1350 E1700-E1702 | Oxygen | E0400-E0499 E1351-E1499 |
| Eyeglass Frames | V2020 | Pen | B0000-B9999 |
| Immunosup- pressive Drugs | J7500-J7506 W9077-W9078 | Prosthetics and Orthotics | L0000-L9999 V0000-V9999 |
| | | Not Otherwise Classified | A4099 |

If you have questions about any story in the Third-Party Update section, please contact the OSMA Ombudsman staff at 1-(800) 766-OSMA.

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Featured Speakers: Dr. Herbert Long, Cardiology; Dr. Donald Swikert, Family Practice; Dr. Gerald Wellbrock, Behavioral Medicine.

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| | |
|---|--|
| Cabin Rates, per person, including airfare from home city and port taxes: | |
| Category 4 | Outside Cabin Norway Deck \$1,865.00 |
| Category 5 | Outside Cabin Promenade Deck..... \$1,805.00 |
| Category 6 | Outside Cabin Atlantic Deck \$1,725.00 |
| Category 7 | Outside Cabin Biscayne Deck..... \$1,655.00 |
| Category 9 | Inside Cabin Various Decks..... \$1,455.00 |

Third and Fourth person in same cabin \$831.00 per person including port taxes and air to San Juan. Our group cruise offers savings of 20% over normal cruise rates for February.

For information regarding the cruise please contact Bob McGurk, 513-777-7595 or Nancy Youkilis at 513-871-1100 or 1-800-626-4932

Itinerary All lectures are conducted while at sea

| | | | |
|-------------|---------------------------|-------------|--|
| February 20 | Depart San Juan 10:00 pm | February 24 | At Sea-Lectures |
| February 21 | At Sea-Lectures | February 25 | Tortola/Virgin Gorda 7:30 am - 6:30 pm |
| February 22 | Aruba 8:00 am - 5:00 pm | February 26 | St. John/St. Thomas 6:30 am - 6:00 pm |
| February 23 | Curacao 8:00 am - 5:00 pm | February 27 | San Juan arrive 8:00 am |



Influenza vaccine reimbursed through Medicare

Effective for services furnished on or after May 1, 1993, the Medicare program covers influenza virus vaccine and its administration when furnished in compliance with any applicable state law and by

any provider of services who has a valid provider number. The vaccine and the administration of the vaccine will be reimbursed only one time per calendar year. In addition, Part B deductible and

coinsurance do not apply.

The influenza virus vaccine should be submitted with code 90724. This code is for the vaccine alone and does not include administration. The administration fee

should be submitted with code Q0124 (administration of influenza virus or pneumococcal pneumonia vaccines). Q0124 is only appropriate when used in conjunction with claims for 90724 (influenza virus vaccine) and 90732 (pneumococcal vaccine).

Hepatitis B vaccine is billed using code 90731. This code is for the vaccine alone and does not include administration. The new administration code W0124 (administration of hepatitis B vaccine) should be used. W0124 is valid only for the administration of hepatitis B and is not to be used for the administration of other types of vaccines.

Nationwide-Medicare has indicated that separate reimbursement for evaluation and management services may be allowed only if the patient is being treated for services related to a separate diagnosis.

If you have questions, contact the OSMA Ombudsman staff at 1-(800) 766-OSMA. ■

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DSI is the distributor for *The Specialty Manager* Deferred Variable Annuity.

Reimbursement

For Administering Vaccines

Influenza vaccine and pneumococcal vaccine (CPT Code Q0124) will be reimbursed at 100% of the following. Hepatitis B vaccine (CPT Code W0124) will be reimbursed at 80% of the following:

Medicare Locality and Payment:

| | | | |
|----|--------|----|--------|
| 01 | \$3.24 | 09 | \$3.14 |
| 02 | 3.27 | 10 | 3.40 |
| 03 | 3.31 | 11 | 3.22 |
| 04 | 3.27 | 12 | 3.12 |
| 05 | 3.21 | 13 | 3.13 |
| 06 | 3.16 | 14 | 3.21 |
| 07 | 3.12 | 15 | 3.13 |
| 08 | 3.22 | | |

For the Cost of Vaccines

The Medicare Part B approved amount for a covered drug is the Average Wholesale Price (AWP) listed in the most current *Drug Topics Red Book*. The following figures are for September 1993 and can change without notice:

90724 (Influenza virus vaccine) –
\$3.78 (Reimbursed at 100%)

90732 (Pneumococcal vaccine) –
\$13.36 (Reimbursed at 100%)

90731 (Hepatitis B vaccine) –
\$53.54 (Reimbursed at 80%)

Report finds Ohio lacking in primary health services

The ACCESS-Ohio Coalition, a statewide group dedicated to improving access to quality health care, has issued a report that takes a look at the level of primary care services available in Ohio. In an executive summary, released by the coalition, the group notes that:

- More than half of Ohio's counties have identified communities where residents have limited or no access to basic primary health care.
- Although Ohio has nearly 33,000 licensed physicians and graduates about 800 more annually, 45 Health Professional Shortage Areas (there are 62 federally designated areas in Ohio) do not have enough primary care providers to care for the community, leaving more than 1.2 million people with limited or no access.
- Even in communities where there are adequate numbers

of primary care providers overall, more than 130,000 people who are Medicaid-eligible or working poor and uninsured have limited or no access to primary care services.

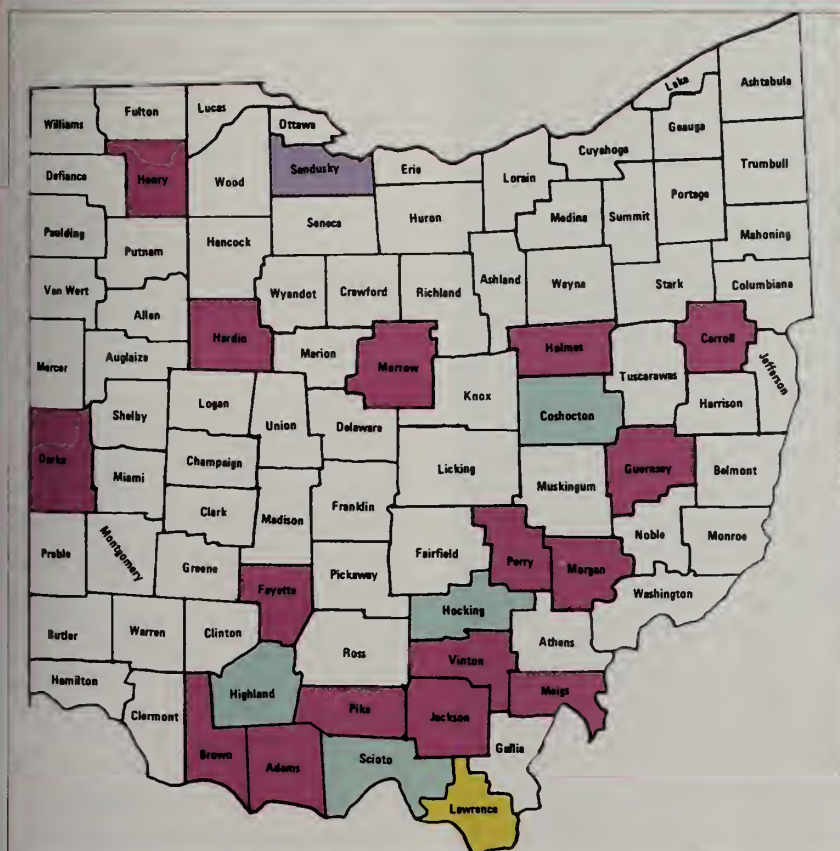
- Nationally, 54% of all ambulatory visits are for primary care services, yet only one-third of doctors are primary care practitioners.
- Only 14.6% of 1992 U.S. medical school graduates are interested in primary care, down from 36% 10 years ago.
- Ohio taxpayers spend approximately \$140 million a year to train doctors at our seven medical schools, yet more than half leave the state to attend residency programs.

Among the coalition's recommendations for addressing these issues are the following:

- Increase the availability of primary care providers.
 - Increase the number of primary care physicians trained and retained in Ohio.
 - Improve the distribution of primary care physicians throughout Ohio.
 - Encourage a primary health-care team approach that effectively utilizes all appropriately trained primary care providers.
- Rethink the economics of primary care.
 - Reverse reimbursement incentives.
 - Reduce state and federal regulations.
- Address the impact of mal-practice liability.
- Streamline administrative procedures.
- Prioritize and widely disseminate the results of primary care research.
 - Increase primary care research.
 - Develop systems to assure the availability of new and proven technology to primary care providers.

A copy of the full report is available for \$15 from ACCESS-Ohio Coalition, Ohio Primary Care Association, 341 South Third Street, Suite 201, Columbus, OH 43215, (614) 224-1440. ■

Ohio's Physician-Shortage Areas



- Entire county lacks sufficient number of physicians
- County lacks physicians to care for poverty population
- County lacks physicians to care for medically indigent
- Lacks physicians to care for Medicaid, migrant population

ATTENTION PHYSICIANS:

ANNOUNCING THE OHIO CONNECTION IN LOCUM TENENS

CompHealth/Kron, the nation's premier locum tenens (temporary physician staffing) organization, has established a local staffing network in Ohio.

That means we have qualified, experienced, *local* physicians available to fill in when your medical practice or facility is short staffed, or when you need daily, weekly, evening, weekend, or routine physician coverage.

It's a great way to make sure your patients have convenient access to quality care in *your* practice or facility.

Call us today to discuss your practice coverage needs, or to find out more about building a flexible, rewarding practice as a locum tenens physician with our Ohio staffing team!

CompHealth/Krōn

THE NATION'S LOCUM TENENS SERVICE

1-800-634-1077

Patient information available by phone

University Hospitals in Columbus has adopted a network that allows physicians to send and retrieve patient information over the phone.

Called the Central Ohio Medical Information Network (COMIN),

the system allows physicians to access a patient's clinical record, and to communicate with other physicians, managed-care companies, pharmacies and insurers.

Using standard phone lines and

an IBM-compatible personal computer, physicians may use COMIN 24 hours a day to send or retrieve information on patients in University Hospitals and The Arthur G. James Cancer Hospital and Research Institute.

Besides offering quicker service and increasing the flow of patient

information, the network is also expected to reduce the costs of manually distributing patient information to physicians.

"We expect to save enough in annual paper and postage costs to recoup the \$145,000 yearly fee we will pay to participate in COMIN,"

Continued on next page

Two med schools name new leaders

Primary care is a primary focus according to two newly appointed medical school leaders, Barbara Ross-Lee, DO, dean of the Ohio University College of Osteopathic Medicine, and Roger Bone, MD, president and CEO of the Medical College of Ohio.

Dr. Ross-Lee, who was formerly associate dean for Health Policy at the College of Osteopathic Medicine and professor of Family Medicine at Michigan State University, is the sister of singer Diana Ross, and also has the distinction of being the first African-American woman dean of a U.S. medical school.

Dr. Ross-Lee says that the medical college will work to better establish a continuum of education that would begin upon admission and continue through primary care residencies.

"There are many kinds of mixed messages that have been created over time about the prestige of the profession," Dr. Ross-Lee notes. "I think it's time to go in a different direction and supply the *needs* of the country for health-care services compared to the *wants* of the country."

Dr. Bone, who is certified in pulmonary medicine, critical care medicine and internal medicine, comes to Ohio after serving as vice president of Medical Affairs at Rush-Presbyterian-St. Luke's Medical Center and dean of Rush Medical College in Chicago.

"I think the national government is right," he says. "There is a tremendous shortage. We need an increasing number of primary care physicians, and it is incumbent on medical schools to try to at least meet a 50% goal."

"Medical schools have to show how much prestige is given to primary care," Dr. Bone continues.

"That's a reversal." ■

— Angela Truglio-Kovalik

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is under our feet as
well as over our heads."

— T H O R E A U

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says Gerald Maier, associate executive director of University Hospitals.

To assure confidentiality, the network has been designed as a store-and-forward system, meaning that no two participants are directly linked to one another, and no user has on-line access to the hospitals'

clinical information systems. Instead, each participant is linked to the COMIN computer center in Columbus, which distributes the necessary information. Also, COMIN will send information only to physicians associated with a patient's case who have obtained prior patient permission.

Information currently available from the network includes admission letters, discharge letters, histories and physicals, operative reports, gastroendoscopy reports and discharge summaries.

By the end of the year, hospital officials say, the network will also allow access to cardiology and

radiology reports, and laboratory results.

To join the network physicians need to have an IBM-compatible personal computer, and a modem, voice package and telephone line. For more information, call Pamela Ancona at 1-(800) 824-8236. ■

Patients to give doctors check-ups

The next patient you examine might well have examined you first thanks to Patient Doctor Check-Up (PDC), a new company in Kent that researches data about physicians. "Patients are employers of physicians," says President Shawn Kruger. "They have every right to know."

PDC's database contains Ohio State Medical Board information on 36,000 Ohio-licensed physicians and, so far, malpractice information from 15 northeastern Ohio counties.

For \$14.95, PDC informs consumers about licensure status, medical school, specialty, years in practice, any malpractice suits or disciplinary actions and, soon, membership in the American College of Physicians.

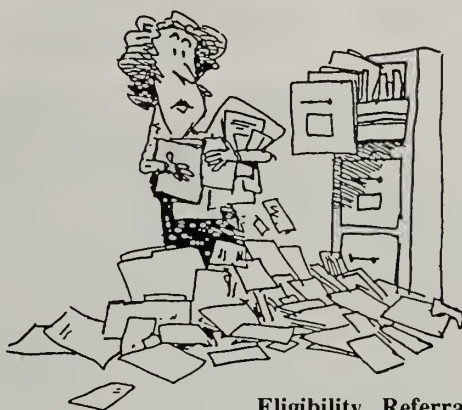
OSMA Fifth District Councilor Ronald L. Price, MD, and alternate delegate to the AMA Jack Summers, MD, say the information does not tell the whole story. "Many times, the best physicians are the ones who are sued because they take on difficult cases," says Dr. Price.

"I'd want to know how many postgraduate seminars they've attended," Dr. Summers says, "their number of academic credits, their current board status and how up-to-date they are."

Kruger says he would like to include board-certification and AMA membership data, but neither the AMA nor the American Board of Medical Specialties has cooperated. In the future, PDC will provide more detailed malpractice information, malpractice rates for different specialties, and a service for physicians to check out prospective, perhaps lawsuit-happy patients.

Operating since May, PDC has filled 150 individual requests. ■

— Jacqueline Hanks



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PHP Benefit Systems, (614) 442-7220 or (800) 328-8835
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Congratulations!

The Nationwide® Medicare Operation wishes to congratulate the providers listed below for billing 90 percent of their Medicare claims electronically. These providers will be individually recognized for their commitment to cost containment and improved quality processing as they move into the twenty-first century. We apologize in advance if any names were inadvertently omitted or misspelled.

| | | | |
|---|---|---|--|
| Acute Care Services Inc. | Diversified Physicians Inc. | Mahoning Valley Emergency Specialists | Queen City Radiologists Inc. |
| Acute Care Specialists Inc. | Doctors Clinical Laboratory | Mansfield Internists Inc. | Radiation Therapy Cleveland Clinic |
| Akron Heart Institute | Dunbar Medical Associates | Marietta Internal Medicine Inc. | Radiologic Consultants |
| Akron Radiology Inc. | E.N.T. Associates of Cincinnati Inc. | Marietta NC Imaging Inc. | Radiological Associates |
| Alliance Medical Specialists Inc. | East Holmes Family Care Inc. | Marshall Family Practice | Radiological Consultants Stonewall Jackson Memorial Hospital |
| Nabil F. Alloush, M.D. | East Liverpool Radiology Associates Inc. | Martinsburg Radiology | Radiology Associates Inc. |
| Kenneth G. Amend, M.D. Inc. | Edgepark Surgical Inc. | Marymount Hospital | Radiology Cleveland Clinic |
| Kowriah N. Amirthalingam, M.D. | Emergency Practice Associates Inc. | Erwin A. Maseelall, M.D. Inc. | Radiology Consultants Inc. |
| Anderson Radiology Associates | Emergency Professional Service Inc. | Medical Associates Zanesville | Radiology Inc. |
| Anesthesia Associates Euclid | Emergency Services Inc. | Medical Center Radiology Inc. | Radiology Service Canton Inc. |
| Anesthesiology Cleveland Clinic | Emergency Services of Dayton | Medical Emergency | Raleigh Radiology Inc. |
| Archbold Medical Group | Endocrinology Cleveland Clinic | Medical Eye Associates Inc. | Regency Park Eye Associates |
| Ashland Internal Medicine | Eye Care Associates Inc. | Medical Service Associates of Xenia | Kevin M. Reid, D.O. |
| Ashtabula Clinic Inc. | Eye Consultants of Huntington Inc. | Medical Specialists Zanesville | Renal Physicians Inc. |
| Aspiration Biopsy Laboratory | Eye Surgery Center Ohio Inc. | Medina Radiology Group Inc. | Riverside Hospital |
| Associated Emergency Physicians Inc. | Fairfield Medical Group | Memorial Imaging Associates Inc. | Riverside Methodist Hospital Pathology Associates Inc. |
| Associated Radiologist | Fairmont General Hospital | Joseph Mersol, M.D. Inc. | Roentgen Diagnostics Inc. |
| Associates In Dermatology | Fairview Eye Center | Metrohealth Radiology | Hira B. Rohela M.D. |
| Aultman Anesthesia Inc. | Family Physicians Associates Inc. | Miami Radiologists Inc. | Rosemar Medical Associates Inc. |
| Aultman Hospital | Family Practice Holzer Clinic | Miami Valley Cardiovascular Inc. | Paul D. Ruff, M.D. Inc. |
| Aultman Pathology Associates Inc. | Family Practice of Toledo | Miamisburg Family Practice Inc. | Sachs Ross and Associates |
| Bayless Pathology Associates | Firelands Radiology Inc. | Mid-Ohio Heart Clinic Inc. | Saint John Medical Center |
| Bethesda Hospital North | First Medical Associates | Mid Ohio Radiology Inc. | Saint Rita's Hospital |
| Bethesda Oak X-ray Inc. | Fremont Eye Center Inc. | Middletown Radiology Associates | Salem Radiologists Inc. |
| Bryan Medical Group Inc. | Gastroenterology Cleveland Clinic | Middletown Specialty Care | Samaritan Emergency Corporation |
| Cabell Huntington Hospital | Gem City Emergency Associates | Midwest Medical Consortium Inc. | Sandusky Internists Inc. |
| Camden Clark Memorial Hospital | Gem City Urologists Inc. | Minardi Eye Center Inc. | Sass Friedman and Associates Inc. |
| Canton Aultman Emergency Physicians | General Anesthesia Service Inc. | Monongalia General Hospital | Burt E. Schear, M.D. Associates |
| Canyon Medical Center Inc. | General Surgery Cleveland Clinic | James L. Moses, M.D. Inc. | Shoemakers Ambulance Network |
| Cardiologists of Clark and Champaign Counties | Genito-Urinary Surgeons Inc. | Mount Auburn Internists Inc. | Smith Clinic Inc. |
| Cardiology Associates of Cincinnati | Atul S. Goswami, M.D. | Bashar A. Mubashir, M.D. Inc. | Anthony G. Sola, M.D. |
| Cardiology Inc. | Greater Cincinnati Cardiovascular Consultants | Mueller and Jennings, M.D. Inc. | South Charleston Cardiology |
| Cardiology Specialists | Greater Cincinnati Gastrology | Neurology Cleveland Clinic | South Dayton Family Physicians Inc. |
| Cardiovascular Clinic Inc. | Greene Radiologists Inc. | Newark Family Physicians Inc. | Southeast Radiology Group Inc. |
| CDC Physicians | Hamilton Radiology | North Dayton Pathologists | Southwest Family Physicians Inc. |
| Central Radiology Consultants | Hematology Medical Oncology | Northeast Ohio Kidney Group Inc. | Springfield Health Care Center |
| Charleston Area Medical Center | Herzig Krall Medical Group Inc. | Northeast Ohio Pulmonary Associates | Springfield Radiology |
| Chillicothe Radiology Inc. | Hill Thomas Company | Northern Hills Radiology Inc. | Ray A. Sinker, M.D. and Associates |
| Cincinnati Cardiac Consultants | Hillcrest Radiology Associates | Northwest Eye Surgery Inc. | Stark County Eye Clinic |
| Cincinnati Fire Division Paramedics | T C Hobbs Associates | Northwest Family Physicians Inc. | Stark Medical Specialists |
| Citywide Ambulance Service | Holiday Medical Supply | Norwalk Clinic | Steuben Radiology Associates |
| Clarksburg Cardiovascular Consultants Inc. | Home Xray Service Columbus | Nuclear Medicine Cleveland | Stouder Memorial Hospital |
| Clarksburg Radiology Group | Home Xray Service Dayton | Nuray Radiologists Inc. | Suburban Medical Laboratory Inc. |
| Cleveland Cardiology Consultants | Phillip L. Horowitz, M.D. | Oakhill Medical Associates Inc. | Summit Medical and Cardiovascular Associates |
| Cleveland Foot Clinic | Huntington Eye Associates Inc. | Kong T. Oh, M.D. Inc. | Sycamore Professional Associates Inc. |
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| Cleveland Skin Pathology | Hypertension Nephrology | Ohio Surgical Specialists | Timken Mercy Hospital |
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WARD D. COFFMAN, JR., MD, Tempe, AZ; University of Cincinnati College of Medicine, 1947; age 70; died July 1, 1993; member OSMA.

BERNARD B. COHEN, MD, Wauseon; Medizinische Fakultät der Universität Heidelberg, Heidelberg, Baden-Württemberg, Germany, 1956; age 67; died June 26, 1993; member OSMA and AMA.

ROBERT F. COOPER, MD, Presque Isle, MI; Ohio State University College of Medicine, 1949; age 68; died August 3, 1993; member OSMA.

WILLIAM COTTON, MD, Hartville; University of Rochester School of Medicine-Dentistry, Rochester, NY, 1954; age 68; died July 27, 1993; member OSMA.

JOEL A. ESSIG, MD, Cincinnati; University of Cincinnati College of Medicine, 1942; age 74; died June 5, 1993; member OSMA.

RICHARD A. FEEZEL, MD, Canton; George Washington University School of Medicine, Washington, DC, 1951; age 66; died July 27, 1993; member OSMA and AMA.

EVELYN GOLOMB, MD, Cleveland; Medical College of Pennsylvania, Philadelphia, PA, 1938; age 79; died July 19, 1993; member OSMA and AMA.

HARVEY C. GUNDERSON, MD, Toledo; Rush Medical College, Chicago, IL, 1937; age 81; died August 1, 1993; member OSMA and AMA.

RALPH F. HENN, MD, Columbus; Ohio State University College of Medicine, 1973; age 45; died July 11, 1993; member OSMA.

DAVID G. JAGELMAN, MD, Ft. Lauderdale, FL; University of London Faculty of Medicine, London, England, 1963; age 53; died August 9, 1993; member OSMA.

RICHARD RABKIN, MD, Dayton; Ohio State University College of Medicine, 1955; age 63; died July 20, 1993; member OSMA and AMA.

THEODORE B. THOMA, MD, Hilliard; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1950; age 67; died July 15, 1993; member OSMA.

CHARLES W. WATSON, MD, Maumee; University of Michigan Medical School, Ann Arbor, MI, 1951; age 71; died July 23, 1993; member OSMA. ■

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1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992.

Agricultural handbook 8-10.

2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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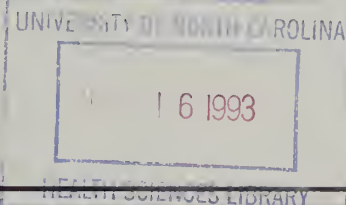


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OHIO *Medicine*

News for Members of the Ohio State Medical Association



OSMA task force outlines proposals

Health reform meetings a success

Photo by Jack Kustron

In Brief: The task force conducted eight regional meetings to present their recommendations for health-care reform.

Nearly 1,000 OSMA members took advantage of eight regional meetings, held across Ohio last month, to learn more about the OSMA's plan for health-system reform.

At each of the meetings, different members of the OSMA Task Force on Health-System Reform provided a brief background of the plan's development, and how it compares with other health-reform models. Then, the report itself – entitled "Shared Goals, Shared Responsibilities" – was presented with the help of a videotape prepared by the OSMA.

The most significant part of each meeting, however, was the question-and-answer session that followed. A panel composed of various task force members and an OSMA officer or councilor was on hand at each meeting to field ques-



From left: Claire V. Wolfe, MD, Mary Jo Welker, MD, and Mark A. Bechtel, MD, speak at the central Ohio regional health-reform meeting.

tions from members about the plan.

TURNOUT INDICATES INTEREST

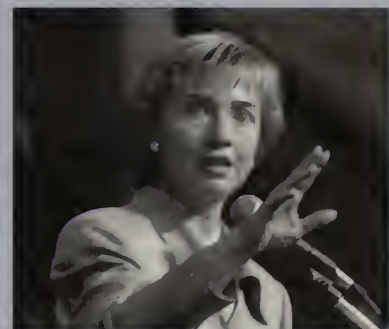
"The excellent turnout at the meetings shows just how interested

doctors are in this issue, and how much they want to be informed," says Daniel W. Handel, MD, a Youngstown dermatologist and

See **REFORM** page 3

Inside

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First Lady Hillary Rodham Clinton

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Health-reform opinions given Ohio docs surveyed

In Brief: In a telephone survey, Ohio physicians said they recognized that the nation's health-care system needs to be reformed, but there were several opinions on how to accomplish that.

Ohio physicians recognize the need for health-system reform and want to participate in designing the changes that will result.

That was the

message conveyed by more than 300 Ohio physicians in a comprehensive telephone survey, sponsored by the OSMA and conducted in August and September by Market Group One, a Columbus-based research firm. The survey was commissioned by the OSMA as part of its effort to play a leadership role in health-care reform in Ohio. The survey attempted to determine the current attitudes of Ohio physicians toward health-system reform, and the differences in attitudes between urban and rural physicians.

Here is a sampling of the survey findings:

What amount of change is needed to reform health care?

- Significant change to current

See **SURVEY** page 3

SRF refund deadline nearing

Physicians who are eligible to receive a refund of the remaining money in the Stabilization Reserve Fund have until the 12th of this month to file an appropriately completed Proof of Claim form, or forever be barred from receiving any of the money.

You are eligible for an SRF refund only if you practiced in Ohio and carried medical liability insurance coverage during the years 1975-1980.

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The SRF refund was made possible through extensive lobbying efforts by the OSMA. ■

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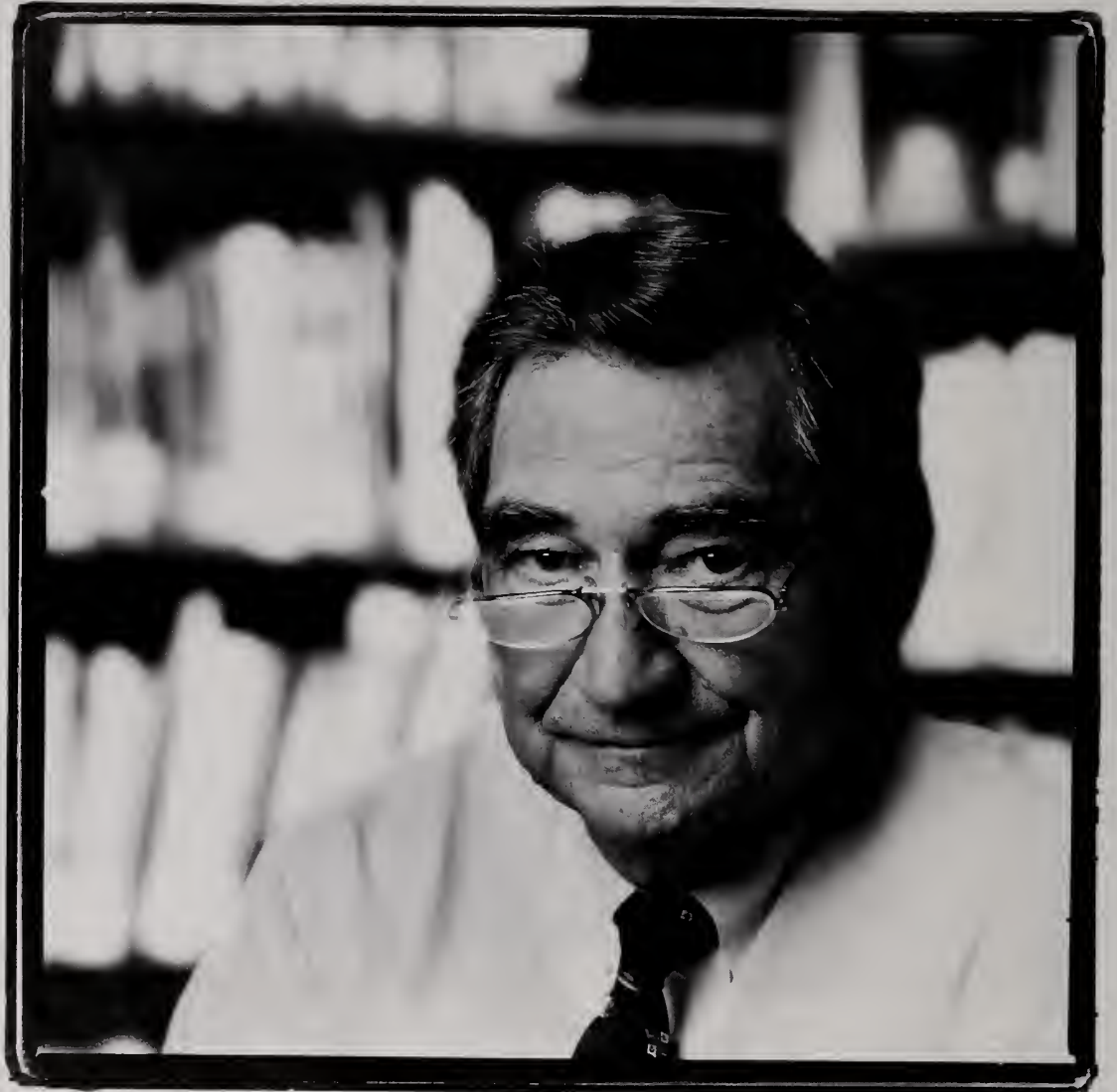
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SURVEY...*From page 1*

system...78% (Rural: 64%)

- Change to a centralized system...10% (Rural: 17%)
- No change needed...9% (Rural: 16%)

What is your opinion about mandated health insurance coverage?

- All employers should provide, but small businesses should get tax breaks...68% (Rural: No figure available)
- Employers should not be required to provide...26% (Rural: 40%)
- Laws mandating coverage should be passed, no tax breaks for small businesses...2% (Rural: 2%)

Ohio physicians accept their responsibility for health-care reform.

Will hospitals, insurance companies, patients and physicians have to make concessions regarding health-care delivery, costs?

- Very likely...73% (Rural: 66%)
- Somewhat likely...22% (Rural: 29%)
- Not at all likely...4% (Rural: 5%)

Do you support physician concessions in reforming health care?

- Somewhat supportive...55% (Rural: 60%)
- Very supportive...19% (Rural: 23%)
- Not supportive...16% (Rural: 11%)

The survey documented the recognition by Ohio physicians of their responsibility to participate in

cost-containment programs and practices. Some of the potential changes that received somewhat favorable support include the concepts of a uniform fee schedule with no balance billing, and practice parameters. A significant proportion of the respondents, however, resisted the concept of single or global billing.

When asked what health-care reform options they agree with, most Ohio physicians indicated support for:

- Tort reform to improve the malpractice climate.
- Regulatory control over administrative expenses of third-party payors
- Incentives to increase the number of primary care physicians
- Financial incentives to physicians to practice in underserved areas
- Prioritizing health-care services, similar to the Oregon plan.

Half of the respondents disagreed that expanding the scope of practice for allied practitioners was the answer.

Finally, physicians were asked what the OSMA could do with regard to health-care reform. The answers:

- The OSMA should not try to resist any significant change in the health-care system...86% (Rural: 78%)
- The OSMA should try to improve access and control costs by implementing reforms through public-private programs...96% (Rural: 95%)

A mail survey, sent to all OSMA members requesting their opinions on health-care reform, mirrors most of these study results.

The results also compare favorably to a survey conducted among Ohio physicians by the Gallup organization in 1991. ■

10-year ban on genetic testing

A House bill restricting insurance companies from using genetic testing to help determine health insurance eligibility passed the Senate in late September, although with some compromise.

Originally, the bill permanently banned the screening of health

insurance applicants for hereditary illnesses or abnormalities.

The compromise bill ends the general prohibition against testing after 10 years. Meanwhile, insurers may consider those test results that are submitted voluntarily. ■



Health Care and the Media

OSMA President Walter Reiling, Jr., MD, speaks at the recent conference, "Health Care and the Media: Reporting Reform," sponsored by the OSMA and the Ohio Hospital Association. The seminar brought together hospital administrators and physicians with reporters and media executives. In the background is Jackie Fullerton, executive director of the Ohio Health Care Board.

REFORM...*From page 1*

task force member who spoke at the regional meeting held in Canton.

All those who attended the Canton meeting, he said, seemed to agree that reform is needed, and there was general support for the OSMA plan.

Of course, at each meeting, a few individual members expressed concern about various aspects of the plan, but the overall feeling was positive.

AN EVOLVING REPORT

OSMA President and task force Chair Walter Reiling, MD, has

referred to the task force report as a "working plan," one that will continue to monitor developments and help in developing OSMA initiatives.

Most of those who attended the eight meetings indicated support for OSMA's proactive stance, and reaffirmed their commitment to participate in health-system reform in Ohio.

"I think the doctors were generally pleased that medicine has its own plan and will have a credible voice in the process," says Dr. Handel. ■

Ohio unveils plan for uninsured

Ohio Gov. George Voinovich has unveiled what he calls a "home-grown proposal" to cover the 1.3 million Ohioans who need health-care insurance.

The proposal, an expansion of the present Medicaid system, offers health-care coverage to all Ohioans under the federal poverty standard (about \$11,000 for a family of three), using a managed-care approach and assuring the same standard benefit package to all. The plan would be implemented over the next five or six years.

According to Arnold Tompkins, director of the Ohio Department of Human Services, the plan is designed to create a "purchasing pool" of patients, sparking com-

petition among health-care providers which, in turn, would allow the state to negotiate lower costs for services. No new state or federal funds would be needed.

"The financing pool is broadened by tapping unmatched state and local dollars that can be used for services, which will be reimbursed by federal matching funds," said Tompkins in a *Daily Reporter* news story.

Gov. Voinovich made his reform proposal now, saying that Ohio cannot afford to wait for Washington to act on the administration's health-care reform proposals.

The plan will go to the Ohio Health Care Board for further consideration. ■

My meeting with Hillary Rodham Clinton

By John A. Devany, MD

Editor's note: In September, a 12-member delegation from Toledo, including OSMA Past President John A. Devany, MD, traveled to Washington at the invitation of U.S. Rep. Marcy Kaptur (D-Toledo), for an hour-long meeting with the First Lady. The following report focuses on some of the health-reform issues discussed at that meeting.

I was privileged to represent physicians at a meeting with Hillary Rodham Clinton and congresswoman Marcy Kaptur. It was a remarkable experience. There was a willingness to listen and admit that health reform is an evolving process that will take eight to 10 years.

I was lucky to be the lead-off batter. I told her of the work of the OSMA's Task Force on Health-System Reform, and that there are many points of similarity between the initial reports of our two groups. The status quo is not an option.



tor relationship (they have one, and will continue to have one), and that a fee-for-service option is a requirement of all alliances. The concept of patient-selected "point of entry" for any specific episode is one she would like to give further study.

She also believes that as primary care compensation improves, those physicians would be less likely to hold onto patients and would refer faster. She suggested that as the system evolved, part of the problem would be solved by education within the profession. She didn't care much for mandatory referral guidelines, stating that medicine doesn't like cookbook solutions.

She is aware that doctors feel



Hillary Rodham Clinton



John A. Devany, MD

feels this may be harder to accomplish because of judicial interpretation, but she realizes the implications of the problem.

With regard to physician participation and negotiating rights, she stated there is money in the plan that will allow physicians to set up their own groups, or even alliances. She looks forward to innovation in these arrangements as the process evolves.

Later, I was able to mention that physicians are very concerned about the RBRVS plan, specifically the portion allotted to office and practice expenses, since these facilities are not in use when in surgery, but most physicians hire full-time employees.

The exclusion of health-care providers from health alliances was discussed. The fear of providers overwhelming the system seemed to be the reason for our exclusion, but why aren't insurers excluded?

The private insurance industry raised objections to the elimination of their jobs, but Mrs. Clinton explained there would be an even larger, long-term care and supplemental market for them.

MEDICARE

There was significant and prolonged talk about Medicare cuts

and funding. She said the aim was to cut the growth factor from 11% to 5%. This led to discussion of special-needs populations (i.e., AIDS, cancer, the homeless, sickle cell, etc.). She discussed placing an emphasis on home-care, or less-than-acute hospital care, community services and public health and education.

It was gratifying that the rest of the group frequently and strongly echoed the importance of freedom of choice of physician and maintaining long-term relationships. She got the message.

She emphasized personal responsibility, primary care, preventive medicine and community education, and repeatedly stressed decreasing the hassle factor, not just for doctors but for patients, hospitals and administrators. The larger employers and the unions were particularly emphatic about not getting less than they already have.

All in all, I left feeling it was a positive experience personally, and for physicians in Ohio. ■

Dr. Devany is a Toledo otolaryngologist.

She emphasized personal responsibility, primary care, preventive medicine and community education.

We then addressed the subject of preservation of quality by stressing that we must maintain a system where physicians are free to be responsible to their patient at all times, not to the government or insurers. We must preserve a patient's freedom to choose his or her physician. This can be done, even in managed-care situations.

GATEKEEPER CONCEPT

The gatekeeper concept sounds great, but it has been shown that early specialty care is more cost-effective, with less time lost from work and less use of antibiotics. Mrs. Clinton stated that she and her husband strongly believe in preserving a personal family doc-

hassled by prospective reviews and she doubts they save money. But retrospective, statistical reviews of large groups of patients can help establish criteria and guidelines, she says, again in an ongoing process.

HEALTH-CARE ALLIANCES

If physicians are going to be forced into some kind of alliance, they must be able to bond together to negotiate terms and conditions. If the RBRVS concept is to be used, different definitions must be debated. At the present moment, fear of antitrust prosecution cripples any such action. She said this is going to require a change in the laws. My impression is that she

Ohio Health Care Board readies recommendations

In Brief: Expect a single-billing form, a basic benefits package, malpractice reform and quality assurance when the Ohio Health Care Board makes its recommendations to the governor.

The Ohio Health Care Board probably won't have a structured plan for reforming the state's health-care system ready for the governor by January 1, says Claire Wolfe, MD, OSMA president-elect and the health-care provider representative on the board. However, the board does expect to make the following recommendations when it presents its report in 1994:

- **A single billing form** – The board will mandate all providers to use a single billing form, probably the HCFA 1500 form.
- **A basic benefits package** – Right now, there is much discussion as to what this package will contain and what it won't. The board's Basic Benefits Subcommittee has sent surveys to various individuals in the health-care

field, asking them what a basic benefits package should contain. At Dr. Wolfe's suggestion, surveys have been sent to members of both the OSMA Council and OSMA's Task Force on Health-Care Reform. In addition, the OSMA has submitted the basic benefits plan developed by the OSMA Task Force on Health-System Reform.

- **Malpractice reform** – This issue was discussed in detail in last month's issue of *OHIO Medicine*, but Dr. Wolfe notes that reform measures could include a \$1 million cap on pain and suffering awards, modification of the collateral source rule, voluntary alternate dispute resolution and limited immunity for physicians caring for indigent patients. A similar limited immunity for obstetricians who treat drop-in patients is still being considered.
- **A quality assurance plan** – There will probably be no quality assurance mandate,

says Dr. Wolfe, but the focus will be on a "healthier Ohio," and practice parameters may be established as a pilot project.

Meanwhile, OSMA President Walter Reiling, Jr., MD, recently presented the board with the OSMA's report on health-care reform (see related story on page 6).

PHYSICIAN VIEWS ARE NEEDED

Peter Somani, MD, director of the Ohio Department of Health and also a member of the Ohio Health Care Board, says that the board's malpractice subcommittee was

driven, to some extent, by plaintiff attorneys who comprised a portion of that committee. He urged Councilors as well as OSMA members to write to other board members, as well as the governor, with physician views on malpractice.

"This is one area where unnecessary costs regularly occur, and where physicians can and should push hard for reform," says Dr. Somani. ■



OSMA's task force introduced

OSMA's Task Force on Health-System Reform began in April and met for five months in 10 full-day sessions.

Twenty-six physicians, plus one physician spouse and one medical group administrator, representing the major medical specialties, practice structures and geographic areas of the state, came together to develop a health-system reform plan for Ohio.

The following members served on the task force:

Walter Reiling, Jr., MD, chair, Dayton; Mark A. Bechtel, MD, Westerville; Thomas C. Fenzl, MD, Wooster; Robert K. Finley, Jr., MD, Dayton; John J. Fitzgerald, MD, Concord; David D. Goldberg, DO, Dayton; Daniel W. Handel, MD, Youngstown; Morton L. Harshman, MD, Cincinnati; William L. Hassler,

MD, Elyria; Charles J. Hickey, MD, Columbus; Susan L. Hubbell, MD, Lima; Eleanor M. Johnson, Columbus; Samuel J. Kiehl, III, MD, Grove City; Unni Kumar, MD, Cleveland; L. Edgar Lee, MD, Columbus; S. Christopher Lee, MD, Columbus; Teresa C. Long, MD, Columbus; Patrick H. Macedonia, MD, Steubenville; Pat T. McNery, MD, Cincinnati; W. Jeanne McKibben, MD, Oberlin; J. Robert Navarre, MD, Toledo; Peter J. Plantes, MD, Cleveland; Robert E. Schulz, MD, Wooster; Ronna L. Staley, MD, Copley; Robert E. Stegemiller, MD, Middletown; J. Craig Strafford, MD, Gallipolis; Mary Alice Streeter, Wooster; Mary Jo Welker, MD, Columbus.

See the President's Perspectives column on page 10 for more about the health-system task force. ■

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Comparison of Clinton to OSMA Health-Reform Proposals

Clinton

OSMA

Universal coverage

All American citizens would be guaranteed health-care coverage under a nationally defined, comprehensive benefit package.

All Ohio citizens would be guaranteed health-care coverage under a state-defined, basic benefit package.

How universal coverage would be provided

Most Americans would be enrolled in regional entities called health alliances, which would negotiate the price of coverage with health plans, offer a range of health plans to alliance members, and collect premiums from employers and individuals.

OSMA supports many concepts of managed competition. Concepts supported by OSMA and embodied in managed competition include: increased access to care, consumer choice of health plans, increased consumer awareness and control, and economic competition.

Companies with more than 5,000 employees would have the option of providing coverage to their employees by creating a corporate alliance.

OSMA supports preservation of the patient's right to choose physician and fee-for-service payment system.

Alliance must offer at least one fee-for-service plan that permits individuals the freedom to choose providers.

Medicaid recipients would be "mainstreamed" into private insurance market.

Medicare would be preserved, but states would have the option of integrating Medicare recipients into alliances.

Medicare recipients would be enrolled in alliances.

Who would pay

Employers would pay 80% of the average premium (pro-rata for part-time) and employees would pay 20% of average premium.

OSMA supports gradual transition from employer-based financing to system that gives individuals greater responsibility for their health coverage.

Self-employed and unemployed would pay entire premium, unless eligible for assistance based on income.

OSMA supports consideration of several new sources of funding to finance increased access to health care: surcharges on health insurance, taxing value of health insurance greater than basic benefit plan, and tax increases on products that have an adverse impact on health.

Individuals would pay higher copayment and deductibles when using doctors outside health plan.

How to control costs

A national health board would be created to oversee the system and set a national health budget that would limit the rate of increase of health spending.

A state health commission would be created to oversee the system. It would: accredit basic benefit packages; assess cost/benefit of technology and therapies; evaluate capital expenditures in health care; and establish a uniform relative value scale for provider services.

If the competitive process does not reduce growth, board would impose mandatory caps on growth of premiums, forcing health plans to spend less.

OSMA supports fiscally sound health expenditure planning as an alternative to rigid budgeting.

Competitive process places some financial responsibility on individuals.

Individuals would be empowered to make cost-effective choices by being informed of prices by physicians, hospitals and other providers. Individuals would also be permitted to establish medical savings accounts to discourage overutilization of health services.

Alliances would negotiate with providers to set a fee schedule.

Physicians would have the legal right to negotiate with health plans.

Emphasis on preventive care

Through universal coverage, more Americans, particularly children, would have access to preventive care.

Through universal coverage, more Ohioans, particularly children, would have access to preventive services. Also, OSMA supports creation of financial incentives such as lower health insurance premiums to people who adopt a healthy lifestyle.

Expansion of primary care services

Increase reimbursement to primary care providers; national commission to direct allocation of residency training slots to achieve 50% primary care ration; authorize nurses to deliver primary care.

Increase reimbursement to primary care providers; restructure subsidies for medical education to encourage more primary care physicians; expand availability of nurses and physician assistants under supervision of physicians.

Simplify system

Adopt standard forms and set standards for automated transactions; adopt quality performance measures using regional data.

Adopt standard forms and set standards for automated transactions; much more data collection needed before extensive practice parameters can be developed.

Medical malpractice reform

Proposes alternative dispute resolution, require plaintiffs to include certificate of merit and limit attorneys' contingency fees.

Propose demonstration project for alternative dispute resolution, strengthen collateral source offset, limit noneconomic damages, adopt four-year statute of repose, and limit attorneys' contingency fees.

OSMA acts on new health-care legislative bills

Presented here are new legislative bills dealing with health-care, and OSMA's position on each.

House Bill 28 – Managed Care, Choice of Physician

Sponsor: Rep. Otto Beatty, D-Columbus

Support

What it Does: Prohibits HMOs from discriminating against minority physicians in managed-care plans.

Current Status: In Ohio House Insurance Subcommittee.

OSMA Position: Support; seek amendment to provide due process for physicians who are terminated.

Senate Bill 157 – Off-Label Cancer Drugs

Sponsor: Sen. Grace Drake, R-Solon

Support

What it Does: Prohibits third-party payors that cover prescription drugs from denying coverage for off-label use of cancer drugs.

Current Status: Passed Ohio Senate; referred to House Insurance Committee.

OSMA Position: Support

Senate Bill 191 – License Radiation Technologists

Sponsor: Sen. Grace Drake, R-Solon

No Position

What it Does: Provides for the licensing of radiographers, radiation therapy technologists, nuclear medicine technologists and dental assistant-radiographers.

Current Status: In Senate Health and Human Services Committee.

OSMA Position: No position, with technical assistance.

Senate Bill 201 – Extend Ohio Certificate-of-Need Law

Sponsor: Sen. Grace Drake, R-Solon

What it Does: Extends existing certificate-of-need law until November 1995.

Support

Current Status: Passed Ohio Senate; referred to House Health and Retirement Committee.

OSMA Position: Support

House Bill 335 – Report Domestic Violence

Sponsor: Rep. Barbara Pringle, D-Cleveland

Oppose

What it Does: Requires physicians and certain other professionals to report suspicion of domestic violence, requires hospitals to adopt protocols for dealing with suspected victims of domestic violence and requires the medical board to adopt rules mandating continuing medical education related to domestic violence.

Current Status: In House Human Resources Committee.

OSMA Position: Oppose

House Bill 343 – Comfort Care Measures

Sponsor: Rep. E.J. Thomas, Jr., R-Columbus

Support

What it Does: Clarifies the ability of physicians to provide the full range of comfort care measures to patients who are terminally ill or in a permanently unconscious state.

Current Status: Passed Ohio House; in Senate Judiciary Committee.

OSMA Position: Support

House Bill 355 – Child Abuse CME

Sponsor: Rep. Jane Campbell, D-Cleveland

Oppose

What it Does: Requires the State Medical Board to

adopt rules specifying which physicians must comply with a mandated four hours of CME on recognition and treatment of child abuse.

Current Status: Passed Ohio House, in Senate Judiciary Committee.

OSMA Position: Oppose

House Bill 367 – Expand Immunization Exemption

Sponsor: Rep. Ronald Gerberry, D-Canfield

Oppose

What it Does: Expands existing religious and medical exemptions from required childhood immunization boosters to include moral reasons and requires the Department of Health to publish materials relating to the purposes and medical risks of immunizations and the exemptions from the immunization requirements.

Current Status: Passed Ohio House, in Senate Health and Human Services Committee.

OSMA Position: Oppose

House Bill 381 – Child Safety Restraints

Sponsor: Rep. Mary Abel, D-Athens

Support

What it Does: Strengthens child safety restraint law requiring that all children under 40 pounds, regardless of age, be secured in a child seat when riding in any vehicle.

Current Status: Passed Ohio House, in Senate Judiciary Committee.

OSMA Position: Support

House Bill 389 – Toxicology and Nutrition CME

Sponsor: Rep. Barbara Pringle, D-Cleveland

Oppose

What it Does: Requires that

applicants for physician licensure have obtained at least three quarter hours training in toxicology and nutrition and requires up to 10 hours of CME every two years in toxicology and nutrition.

Current Status: In House Health and Retirement Committee.

OSMA Position: Oppose

House Bill 451 – License Recreational Therapists

Sponsor: Rep. Paul Jones, D-Ravenna

No Position

What it Does: Renames the Ohio Respiratory Care Board and requires the licensure of recreational therapists, RT consultants and assistants.

Current Status: In House Health and Retirement Committee.

OSMA Position: No position

House Bill 463 – License Marital and Family Therapists

Sponsor: Rep. Paul Jones, D-Ravenna

No Position

What it Does: Provides for the licensing of marital and family therapists and gives authority to conduct licensing activity to counselor and Social Worker Board.

Current Status: In House Health and Retirement Committee.

OSMA Position: No position

House Bill 469 – Regulate HMO Contracts

Sponsor: Rep. Mike Stinziano, D-Columbus

No Position

What it Does: Prohibits HMOs from altering provider panels during a subscriber's contract period unless otherwise exempted.

Current Status: In House Insurance Committee.

OSMA Position: No position ■

Mandated AIDS reporting for physicians not recommended

Background: The Ohio Department of Health formed a task force last year to examine whether or not physicians should be required to report their HIV status. The task force was created by a bill passed by the Ohio Legislature. Under the original version of House Bill 419, HIV- and HBV-infected health-care professionals were mandated to notify the ODH, appropriate state licensing board, any health-care facility in which they practiced and certain patients of their HIV- or HBV-positive status. Because of concerns expressed by the OSMA, the final bill was modified to create the ODH task force, which was to develop guidelines and recommendations consistent with those of the CDC.

Update

An Ohio Department of Health Task Force has recently decided not to include in their recommendations a mandate for physicians and other health-care professionals to report their HIV- or HBV-positive status. However, their recommendations do call for the creation of a statewide review panel within the ODH, as well as institutionally based review panels to assess these cases on an individual basis.

Physicians would voluntarily seek guidance from panels within their institutions, or from the state-

wide panel if an institutional panel is not available, and panel members would make recommendations regarding the continued performance of the infected health-care professional's occupational duties.

Additionally, physicians and health-care professionals would be required to adhere to the universal precaution guidelines developed by the CDC and established in administrative rules by the state medical, dental and nursing boards. Strict adherence would also have to be made to appropriate infection-control procedures consistent with the standards adopted by the CDC and the Occupational Safety and

Health Administration, together with improved training and continuing education.

The draft report also strongly recommends that health-care professionals know their HIV/HBV status, but mandatory testing is not recommended and "should not be a condition of employment, licensure or certification."

The medical board's position, however, requires physicians who test positive for HIV to report their status to the board (see *OHIO Medicine*, January 1993).

The report now goes to the Ohio Legislature for discussion and action. *OHIO Medicine* will keep you posted on the outcome. ■

Bill allows enrollees to choose pharmacist, not physician

A Senate bill that began as no more than legislation correcting technical flaws in the Workers' Compensation reform law that passed this summer now includes one non-technical change that has the OSMA insisting that physicians be treated the same.

A provision in Senate Bill 212 grants enrollees in the bureau's managed-care plan the freedom to choose a pharmacist, but the mandated managed-care program under which all other health-care providers must operate remains in place.

"Why should freedom of choice be extended only to pharmacists and not other health-care providers?"

"Sen. Robert Burch (D-Dover) brought to the Senate floor the same arguments as the OSMA," says John Van Doorn, director of OSMA's Department of Legislation. "Why should this freedom of choice be extended only to

pharmacists and not other health-care providers, especially physicians?"

Despite the question, senators remained unconvinced that the provision should extend to other providers, and when the bill

passed the Senate in early October, freedom of choice in the Workers' Comp system remained limited to pharmacists.

The OSMA is now making the same arguments to House members, and by the time you read this, discussion on this issue will probably be reaching a peak in the House Commerce and Labor Committee, chaired by Rep. Ross Boggs (D-Andover).

OHIO Medicine will provide more details on the outcome of this bill as they become available. ■

Ohio's local health departments may get overhaul

Ohio's 152 existing local health departments would be abolished and new, more autonomous ones – one per county – would take their place if a report prepared by a legislative study committee is eventually approved.

Last summer, House Bill 179 established the Ohio public health service study committee to review Ohio's public health system and recommend changes.

"We looked at the system as though we were starting from scratch," says Maurice Mullet, MD, Berlin, who chaired the committee and who serves on the OSMA's Legislative Committee.

As a result, the group drafted among its recommendations a different configuration of local health

The committee is not consolidating local health departments.

districts. These new services would have full authority and responsibility for assessing the health status of their population groups, devel-

oping policy and taking appropriate action to ensure that local health-care needs are met.

"There was some apprehension and misunderstanding on this matter when we took the report to regional hearings in September," says Dr. Mullet. He stresses that the committee is not consolidating local health districts but is instead outlining a new system of local health care.

"As changes occur in the health-delivery system, we'll begin to see some changes in the services local health departments provide," says Dr. Mullet. As coverage for a basic health-care package is mandated,

local health departments will be involved in fewer personal clinical services and will begin to engage more frequently in assessing the health and preventive needs of their communities, and acting to meet those needs.

The committee's final report will be sent to Gov. George Voinovich, House Speaker Vern Riffe and Senate President Stanley Aronoff later this month.

"We expect legislation to be drafted from our report, and introduced at the Statehouse next session," says Dr. Mullet. ■

Keeping pace with PACs

The OMPAC board wants physicians to know how the OSMA's political contributions compare to that of other health-related groups. However, these figures tell only part of the story.

For instance, there are fewer than 2,000 chiropractors licensed in

Ohio compared to 30,000 licensed physicians. Those 2,000 chiropractors are clearly much more active in politics than Ohio's physicians.

If you have not already done so, please join OMPAC. Help the medical profession compete in the political arena. ■

| ORGANIZATION | 1992 EXPENDITURES |
|--|-------------------|
| Law firm retained by BC/BS of Ohio (Cleveland) | \$378,000 |
| Trial lawyers | \$325,000 |
| OMPAC-OSMA | \$229,000 |
| Chiropractors | \$192,000 |
| Hospitals | \$129,000 |
| Optometrists | \$96,000 |
| Community Mutual BC/BS (Cincinnati) | \$50,000 |
| Podiatrists | \$37,000 |
| Osteopathic physicians | \$23,000 |

Note: This list contains only a few of the political action committees that operate in Ohio and does not include many of the state's largest PACs, which are run by organized labor. The information reported was compiled by the office of Ohio Secretary of State Bob Taft.

Status of pending health-care bills

Here's an update on a few of the health-care bills that have been reported in *OHIO Medicine*. For more information on these bills, or for information on those bills not listed here, contact the OSMA Department of Legislation.

- **Assisted suicide** – Three bills establish criminal penalties for anyone who attempts to assist another person in the commission of suicide.

Status: House Bill 18 is in the Ohio House Judiciary Committee. Senate Bills 7, 9 and 24 are all in the Senate Judiciary Committee.

- **Physician/patient sexual contact** – House Bill 102 would amend the Medical Practices Act to provide that the medical

board could take disciplinary action against a physician who engages in sexual contact with a patient.

Status: In Ohio House subcommittee – Civil and Commercial Law. Legislation rendered moot by Ohio Supreme Court decision finding that sexual contact with patients, even if consensual constitutes failure to maintain minimal standards of care.

- **Ohio universal health security plan** – House Bill 341 creates a statewide, publicly financed managed competition program covering all health-care services for Ohio residents.

Status: In House Health and Retirement Committee. ■

PTs to get independent status?

Rep. Wayne Jones (D-Cuyahoga Falls) has recently introduced House Bill 498, which would permit physical therapists to practice independently.

The bill repeals the requirement that physical therapy can be provided only with a prescription or upon referral from a physician, chi-

ropractor, dentist or podiatrist. In other words, if the bill should pass, physical therapists could actively recruit patients and patients could self-refer.

Although the OSMA has no formal policy on this issue yet, it is expected to oppose the bill. ■

Ohio reps introduce health-card bill

Two of Ohio's congressional representatives are the prime sponsors of a House bill designed to allow nationwide use of the health security card that has been made a centerpiece of the Clinton administration's health-care reform plan.

Reps. David Hobson (R-Springfield) and Thomas Sawyer (D-Akron) introduced the bill in September.

The card would give physicians quick access to patients' insurance

and medical records anywhere in the country.

The legislation also creates a health-care data panel, which would establish standards for the data exchange, as well as patient privacy rights.

MedPower, a company that processes health-information, is working with Ohio's government and businesses to establish a statewide information network that would begin in Dayton next year. ■

Bill would license medical technicians

Two bills introduced recently in the Senate would require medical technicians to acquire licenses if they wish to continue to practice.

Senate Bill 191, sponsored by Sen. Grace Drake (R-Solon), provides for the licensing of radiographers, radiation therapy technologists, nuclear medicine technologists and dental assistant-radiographers.

Meanwhile Senate Bill 194, sponsored by Sen. Alan Zaleski (D-Vermilion), tightens laboratory regulations even further by providing for the licensing of clinical labs and lab staff.

The intent of both is to reduce the number of unqualified persons performing tests, says John Van Doorn, director of OSMA's Department of Legislation, but the OSMA has taken no position on either bill.

CLIA '88, the omnibus federal legislation dealing with clinical labs, reduced the qualifications of lab personnel to such an extent that high-school graduates can be trained to conduct lab tests. The state believes these qualifications should be tightened, and a pro-

vision in the CLIA regulations says the states can run their own regulation programs if they wish to do so. Only a handful of states have established such programs, however.

"If these bills pass, physicians who use these technicians in their offices will have to hire only licensed technicians in the future," says Van Doorn. Senate Bill 194 currently contains a grandfather clause that exempts those unlicensed technicians already employed, however SB 191 does not include a grandfather clause for those currently operating radiography equipment in physicians' offices.

For additional information on pending legislation and OSMA's position, see page 7. ■



Sen. Drake

PRESIDENT'S PERSPECTIVES

Health-system task force deserves credit

By the time this issue of *OHIO Medicine* reaches you, I hope you will have received and reviewed your copy of *Shared Goals, Shared Responsibilities*, the report of the OSMA Task Force on Health-System Reform.

Some of you may have even had the opportunity to attend one of our regional meetings to discuss and review the OSMA proposal. I also hope you'll agree with the intent and direction of our plan. As I have stated many times, it's likely no one will agree with each and every facet of the proposal.

In writing this column, however, I don't wish to discuss or debate the content of the report. Rather, I would like to outline the process of its creation and pay tribute to the many unsung heroes who outlined our goals, defined our responsibilities, delineated our position and prepared our document. Both our physician-based task force and our OSMA staff deserve considerable credit.

The task force met for 10 full-day sessions, beginning in April. Attendance was outstanding. Each mem-

ber was provided with literally thousands of pages of documents relevant to health-system reform. Every issue was openly debated and discussed at length by the entire group. The final proposal was generated entirely by the task force. To me, the process was both enlightening and stimulating. Total

"Total agreement was almost never present, but consensus always evolved."

agreement was almost never present, but consensus always evolved, even if the discussion was long and sometimes spirited. I was very proud and impressed that our physicians were able to put aside their own personal agendas and, in many cases, the agenda of the specialty they represented, to draft a proposal they felt was best for all

Ohioans. Perhaps one medical student attending as an observer summarized it best when he said: "I can't believe how unselfish and patient-focused this group is." What better example, what better legacy can we give to our young physicians-to-be? I only wish each of you would have had the opportunity to attend one of our meetings. I believe you also would have been inspired.

In the back of the report and elsewhere in this issue, the task force members are listed (see page 5). If you happen to know one of these individuals, or even if you do not, why not take time to thank him or her? A handshake, a pat on the back, a phone call or even a short note saying "Thank you" would be most appreciated and appropriate.

I can't close without a special word of thanks to the OSMA staff. From the top and through all the ranks, there has been total commitment for this project. Special applause is deserved by the Legislative and Communications de-

Walter A. Reiling, Jr., MD



partments. The last several weeks have been particularly difficult. I'm sure intense effort and many extra hours were devoted to the production and introduction of the report.

Finally, to you, the thousands of members who participated in the surveys, responded to the questionnaires and who volunteered ideas and suggestions, we deeply appreciated and valued your participation.

Remember, as the health-reform debate begins in earnest, it's vitally important that our profession not only participate, but also provide leadership. ■

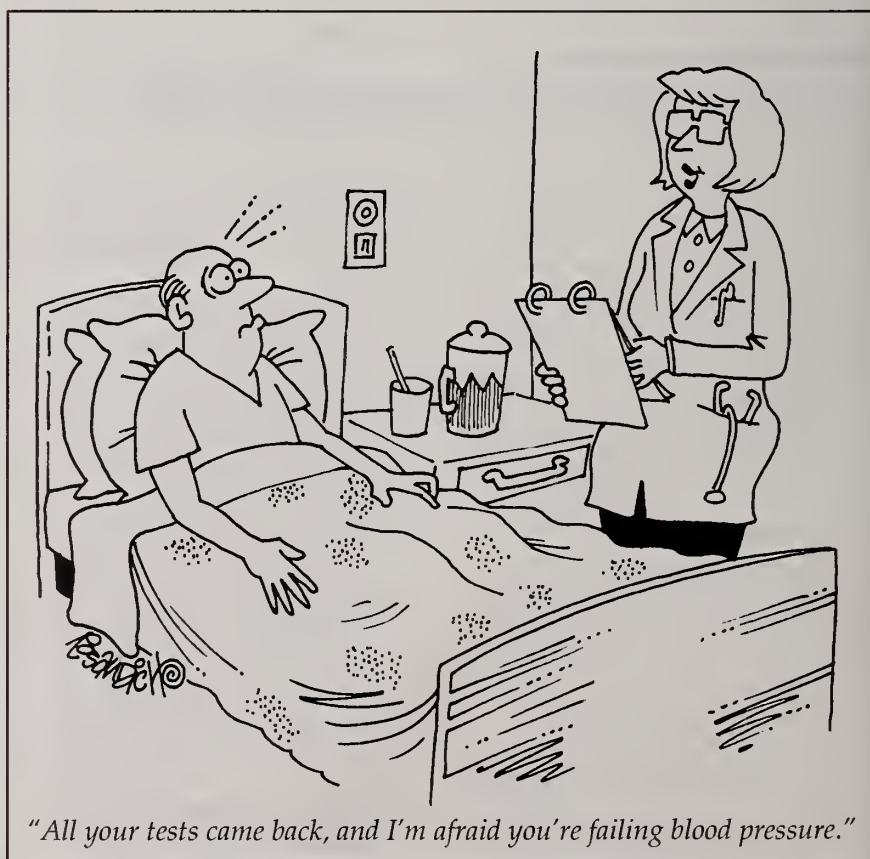
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LETTERS TO THE EDITOR

The danger of managed care

To the Editor:

After 41 years in the practice of primary care medicine in my hometown, I've closed my office. The timing of this move is particularly appropriate because of the pending upheaval in traditional medical care.

There is, at present, a great urgency for health-care reform. Most of this is supposed to come about via "managed care" with an HMO. The great danger with managed care is that it's not possible to successfully separate responsibility and authority. The physician has the responsibility for the patient's care, yet under managed care, he or she does not have the authority to use the tools of the trade. The authority lies with an insurance company or other absentee bureaucrat who hasn't seen and examined, or knows the patient.

You cannot separate responsibility and authority. I'm not sure our populace understands that if their doctors are responsible for correct diagnosis and treatment, they can't have their hands tied by a managed-care bureaucrat (intent on saving money), who is often a high-school dropout sitting at a computer terminal in a distant city.

J.R. SHEETS, MD
Portsmouth

Wound dressings should be kept dry

To the Editor:

This is in response to Dr. William Rogers' observations about aftertreatment of sutured lacerations ("Viewpoint," *OHIO Medicine*, September 1993 issue).

Preventing bacteria from migrating into a wound from the surface is important in minimizing the risk of skin wound infections. The coagulum that forms in the first few days after suturing is an important natural barrier to wound contamination. This material is essentially invisible if the wound edges are well-approximated, but may appear as a scab if perfect closure cannot be obtained.

Dressings serve many important functions. They protect the wound surface until the natural barriers become effective. They help to immobilize involved body parts; this isn't always important but can be crucial with a laceration at high risk for infection, such as a human bite wound near a tendon sheath. They also discourage meddlesome treatment, such as application of iodine or other caustic agents, by the patient or family.

There are two reasons for telling patients to keep their dressings dry. If a dressing gets wet and cannot dry out promptly, bacteria can be wicked from the outside to the wound surface. Also, prolonged wetting of the coagulum causes it to become macerated and lose its protective function.

As Dr. Rogers indicated, there has been a trend in recent years to leave sutured wounds open to the air rather than covering them with a dressing. This is more convenient than the old way and appears satisfactory for low-risk incisions and lacerations that have been closed completely.

It has become common to instruct patients to wash the area twice daily, although I haven't seen any evidence that this is better than washing only as necessary for general cleanliness. The practice might have increased the risk of wicking moisture and bacteria into the tissues in the days of braided silk or cotton sutures, but it doesn't appear to be problematic with today's monofilament stitches. Maceration isn't likely to be a problem if the skin is dried promptly after washing. In other words, the issue is not whether the skin gets wet, but whether it stays wet.

Dr. Rogers mentioned a paper describing a series of 100 lacerations treated with twice-daily washing with no infections. I haven't seen the

report, but would be inclined to rely on it only if it was a controlled study, in which an equivalent number of patients not so treated had a significantly higher infection rate. Perhaps the group of 100 patients would have healed just as well if they were treated with "watchful neglect" alone.

ROBERT D. GILLETTE, MD
Poland

Dr. Rogers replies: The reference for the paper mentioned in my article is as follows: Noe, JM and Keller, M. Plastic and Reconstructive Surgery 81: 82-84, January 1988.

Details of elderly patient's death clarified

To the Editor:

I am responding to the article "Hamilton County debates homicide ruling," featured in the Legal section of the September issue.

Several facts need to be clarified:

First, there was no cancer of the esophagus, nor cancer of any body part. It's true that the deceased had been a hospice patient, but she had a massive left cerebral infarction in the distribution of the left middle cerebral artery and several smaller cerebral lesions.

Second, the estimated dose of Roxanol oral solution that was administered was at the minimum, 120 ml. of Roxanol (2,400 mg. of morphine) and at the most, 160 ml. of Roxanol (3,200 mg. of morphine). Each ml. of Roxanol contains 20 mg. of morphine. The normal dose of morphine sulfate to control pain is 10 to 30 mg. every four hours or as prescribed by the physician.

While the next statement, "the prosecutor chose not to prosecute the case" is theoretically correct, the fact is that the case was presented to the grand jury, and the grand jury chose not to indict a suspect.

FRANK P. CLEVELAND, MD
Hamilton County Coroner

Marketing "exclusive" specialists questionable

To the Editor:

I would like to notify *OHIO Medicine* readers that twice I have been contacted by a Cincinnati marketing group with the offer to have a health profile of me done in *Newsweek*, *U.S. News and World Report*, *Sports Illustrated* and *Time* magazines.

This is presented as an "exclusive" profile, so that only one gastroenterologist in the Akron/Canton area would be profiled. Only late in the discussion do they mention the fees for these ads. In consulting with my various friends, each gastroenterologist in the area has been sought as the "exclusive" specialist.

I would like to let the Ohio State Medical Association know that these marketers are operating in this fashion, and make *OHIO Medicine* readers aware of this questionable activity. I'm sure what these marketers are doing is legal. I'm not so sure I would call it ethical.

JAMES F. KING, MD
Canton

SECOND OPINION

Fix the Workers' Compensation system

Editor's note: The following letter was sent to Gov. George Voinovich this past summer, along with recommendations for reforming the system. The letter represents the author's views, and do not necessarily reflect those of the OSMA or the association's Workers' Compensation committee.

Dear Gov. Voinovich:

This letter is to refocus your attention to "the injured worker." Their status can be described only in terms of "medically endangered, frustrated, administratively abused and manipulated."

This system should provide the safest work environment possible and make available quick medical attention for occupational injury or disease. Instead, we have the delay and manipulation of claim diagnosis and treatment, and treatment by business, self-insured representatives, state administrators and attorneys. The bureau has remained progressively unable to manage the system with computer support, and claim supervision is chaotic at best. Charts are lost or unavailable, and it's virtually im-

possible to have a simple phone communication with anyone capable of solving a single problem of patient care in reasonable time.

Administrative hearings take months and are appealed as a tactic to further frustrate the injured worker and the treating physician. Treatment can't be provided with-

In short, the Workers' Compensation System is a disaster.

out approval, subject to the frivolous scrutiny of unqualified personnel and administrative hearing delays.

I've spent valuable time serving with other physicians on a committee regarding the Workers' Compensation system, under the aegis of the OSMA. The highest-ranking personnel for the Bureau of Workers' Comp have met with

the committee, but have failed to correct serious problems that deal with workers' needs, treatment and rehabilitation. This can only be judged as a failure to help the worker.

Ten years ago, I moved from Cleveland to a rural northwestern Ohio region, and my ideal was to provide primary and specialty neurological care to an area devoid of same. I provide over 60 hours per week on day and night care, to thousands of patients with neurological disease and injury. One of my areas of specialty is pain, which involves a growing number of injured workers.

The government says it wants physicians in rural areas, but let me briefly relate my experience: I'm near the lake in a safe, beautiful area, and treat a large number of grateful patients and injured workers, whom I'm privileged to serve. I believe I charge less than the urban physicians in my specialty, and work longer hours. Yet I need six workers to manage the paperwork, telephone and other communications necessary in this line of

William Bauer, MD



work. Much of this is administrative time spent with Workers' Compensation forms that are lost, are unnecessary, or are simply not given attention or action.

I can no longer attempt to treat patients in such a flagrantly incompetent and insensitive system. Patients wait months for treatment of serious injury.

In short, Gov. Voinovich, the Bureau of Workers' Compensation system is a disaster – more so than any sector of the health system. I plead with you to respond to my concerns for my injured patients. ■

William R. Bauer, MD, is a Bellevue neurologist.

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Recommendations for Reform

Dr. Bauer suggests the following recommendations for Workers' Compensation reform:

- An industrial claim number should be issued within 24 hours, and the patient should reserve freedom of choice of physician.
- Administrative review should be done concurrently.
- Mandatory hearings should take place within weeks.
- Independent opinions should be obtained by physicians familiar with work injury and disease, and opinions should be monitored to prevent repeated appeals used by industry.
- Legal reform should take place to prevent further delays.
- There should be mandatory rehabilitation.
- Self-insurance programs should be monitored to ensure that they are properly compensating workers.
- There should be vocational retraining services if necessary. ■

OHIO Medicine welcomes Second Opinion pieces, but reserves the right to edit as necessary and to reject those not suited for an OSMA publication.

Clinics without walls: Another option

In Brief: "Clinics without walls" allow solo physicians to remain in independent practice, yet have a working relationship with other physicians, similar to group practice arrangements. While clinics without walls ease many of the administrative and business burdens of the solo practitioner, they are not without drawbacks.

Independent physicians can have the best of both worlds in "clinics without walls," a new health delivery system that allows physicians to form a corporate relationship with other physicians without physically moving in together. The concept may well be the saving grace for private practice. Now a solo practitioner can stay in his/her own office, yet have the clout of a group.

This is how it works. Physician-members of these groups handle the day-to-day affairs at each site, but have centralized services for administration, purchasing, billing and collection activities, all under a legal umbrella.

The Outreach Professional Services Inc. (OPSI), operating out of Cleveland, started its clinic without walls concept in 1989 and grew from one physician to 21 within a two-year period. It now operates eight sites, all located in the eastern suburbs. The program is affiliated with Saint Luke's Hospital.

"The established physicians are very comfortable with the program. They are able to keep their own patient base, their same site and practice the way they have been practicing," according to Carolyn Enders, director of operations at OPSI. "A few years ago we were out promoting and recruiting members – now they're coming to us," she says.

DIFFERS FROM A GROUP

Unlike joining a large group practice, members of clinics without walls are not subject to a common set of operational policies and procedures, which have a tendency to decrease a physician's individuality and control. The patient/physician relationship remains intact. The patients do not feel like they are dealing with a large corporation. Although billing state-

ments come from the main office of OPSI, the individual physician's name is at the top of the statement and billing inquiries are made at the physician's office, not the corporation.

"Sooner than expected, networks of physicians will no doubt be competing with each other for patients. Physicians who are not in some type of group practice will find it difficult to get contracts," says David Sobczak, a member of the OSMA Group Practice Advisory Task Force and chief financial officer with the Toledo Clinic, which operates satellite clinics similar to clinics without walls.

Clinics without walls also give physicians more bargaining power with managed-care entities, insurance companies and other third-party payors. Now these "incorporated" physicians have an opportunity to negotiate more favorable contracts than if they were on their own.

SAVING MONEY

By merging their practices, physicians actually save money in terms of staff and purchases. Costs are cut by centralizing bookkeeping and purchasing. Physicians are also able to negotiate better discounts on supplies, equipment and health insurance for employees.

The main concern of clinics without walls is revenue. "You must come up with an income-sharing formula," says Sobczak. "In some clinics without walls each physician tracks his/her own collections and charges and shares expenses. Each physician's salary is based on the revenue he or she generates." At OPSI, Enders says, initial contracts are signed and negotiated by the physicians prior to joining the corporation. Group members do not necessarily make the same salary.

NOT WITHOUT DRAWBACKS

Getting independent-minded physicians to think as a unit can be a drawback. Physicians will likely dicker over fee schedules, pension plans, expenses and compensation. OPSI members air their opinions on medical issues and fees at board meetings.

CALENDAR

The OSMA, in association with Conomikes and Associates, Inc., has planned the following practice management workshops for 1993.

Managed Care

Preparing for the Clinton Health Plan

This one-day course will show physicians and their office staff how to reorganize their medical practice under health reform, how to track results under managed care, how to evaluate contracts, how to maximize collections, and how to deal with gatekeepers.

- Nov. 2 Dana Center at MCO/Hilton, Toledo
- Nov. 3 Parke Hotel, Canton
- Nov. 4 Sheraton City Center, Cleveland
- Nov. 16 Concourse Hotel, Columbus
- Nov. 17 Holiday Inn/I-675, Fairborn
- Nov. 18 Kings Island Inn, Cincinnati

The following are sponsored in cooperation with the AMA's Financing and Practice Services, Inc., and the AMA Investment Advisers, Inc.

Gearing Up For Retirement

- Nov. 9, 10 Columbus Hilton North, Worthington

This workshop covers all sides of retirement – professional, personal and financial. It focuses on short-term financial planning to maintain your lifestyle through retirement, how to cope with inflation, how to measure assets and financial needs, and tax and estate planning.

Starting To Practice Smart

- Nov. 10, 11 Columbus Hilton North, Worthington

Joining A Partnership or a Group Practice

- Nov. 12 Columbus Hilton North, Worthington

These two workshops, aimed especially at residents and young physicians, will show physicians how to take care of business while they take care of patients. The seminars will focus on the pros and cons of group practice, how to value a practice, the costs of practice, how to track receivables and payables, and how to choose accountants, lawyers and other advisers.

Another disadvantage to clinics without walls is that a group culture is never developed since physicians maintain their own offices. It is also difficult to formulate capital development for office expansion. Governance issues become more cumbersome when physicians aren't located in a central site.

Some talk has been generated about the possible violation of kickbacks and self-referral laws. Others have raised the question of possible violation of antitrust laws. However, according to Bill Latimer,

legislative and regulatory analyst with the American Group Practice Association, "There is nothing inherently wrong with clinics without walls – in fact, they can be seen as a positive first step toward coordinated delivery systems for solo practitioners and small groups. But they should not be done to get around current self-referral laws."

The best advice is to consult with a competent legal counsel prior to joining a clinic without walls. ■

Membership offers a 10-1 return on your investment

Add up the services the Ohio State Medical Association provides its members, and you'll find a 10-to-1 dividend on each dues dollar.

Consider this: If bought by non-members, the insurance programs, publications, financial services, leasing services (equipment and auto), and the various practice management seminars offered by the OSMA would add up to \$4,234. (see chart at right for a more complete list). Members, however, receive all of these services for the price of their annual \$395 membership dues.

And that's just the tangible benefits. OSMA members also receive intangible benefits from OSMA's lobbying efforts, as well as from the association's legal and ombudsman services, which help physicians with third-party claims filing, reimbursement, contracts and dispute settlements.

However, if you're a member who is not taking advantage of these benefits, you're not getting the best possible return on your investment.

To learn more about any of these services, complete the information reply card elsewhere in this issue of *OHIO Medicine* and send it in as soon as possible. It may be the best investment move you make all year. ■

| Annual Dues | | \$395 |
|--|---------|---------|
| Member Benefits | | |
| Insurance | | |
| Workers' Compensation Group Rating Program | \$512 | |
| Level Term Life Insurance | 170 | |
| Term Life Insurance | 19 | |
| Disability Income Insurance | 520 | |
| Long-term Care Insurance | 96 | |
| Publications | | |
| Physicians' Guide to Ohio Law | \$50 | |
| <i>OHIO Medicine</i> | 35 | |
| Financial Service | | |
| Patient Payment Bank Card Program | \$75 | |
| Financial Profile | 500 | |
| Collection Service | 555 | |
| Equip/Auto Lease | | |
| Equipment Leasing | \$39 | |
| Automobile Leasing | 258 | |
| Practice Management Seminars | | |
| How To Run a More Profitable Practice | \$30 | |
| Medical Office Management Institute | 50 | |
| Starting Your Practice | 100 | |
| Joining a Partnership or Group Practice | 60 | |
| Gearing Up for Retirement | 65 | |
| Improving on Practice Productivity and Performance | 55 | |
| Managed Care: How to Deal With Profitability | 35 | |
| Miscellaneous | | |
| Participating Physician Contract Review | \$1,000 | |
| Domestic Violence Kit | 5 | |
| Living Will Kit | 5 | |
| Annual Savings | | \$4,234 |

AMA offers managed-care resource service

One way physicians can keep up with the changes in managed care, fee-for-service and health-system reform is to subscribe to the Doctors Resource Service (DRS) offered by the American Medical Association.

Each issue of DRS includes practical handbooks and audiovisual aids – everything you need to know about managed care.

DRS will cover topics such as: dealing with federally proposed health-system reform; options for fee-for-service practice; and evaluating the legal and financial implications of a managed-care contract.

The first issue contains three publications: *The Physician and Managed Care*, *Assessing Your Practice in an Age of Reform*, and *Group Practice Options: From Medical Corporations to Clinics Without Walls*. Also included are an audiocassette, *Alice Gosfield, MD on Physicians' Rights in Managed Care*, and a videocassette, *Managed Care Overview*.

Cost for members is \$39.95 and \$66.95 for nonmembers. To subscribe, call the 24-hour order number, 1-(800) AMA-1066, Dept. CEAD25. ■

OSMA to educate physicians on elder abuse

By law, physicians must report any signs of elder abuse or neglect to the County Department of Human Services. Failure to report such abuse can result in fines of up to \$500 – but often, health professionals miss signs of elder mistreatment because they are unaware of the extent of the problem, or are uncomfortable reporting it.

CAMPAIGN KICK-OFF

That's why, after the first of the year, OSMA will begin to educate its members about elder abuse and mistreatment, the final segment of its three-part campaign on family violence. Earlier educational efforts focused on domestic and child abuse.

For this final program, the OSMA

Department of Communications is preparing an educational handbook that will include clinical guidelines, legal considerations and a list of county agencies to which physicians should report suspected cases of elder abuse. Also included will be a list of community agencies that deal with elder abuse and a display for physicians' offices. Information in the handbook will address elder abuse in both residential and group living situations. An educational video, designed for physicians, will be available at a later date.

The Communications Department expects to begin mailing the kits in early January to members in the following specialties: family and general practice, geriatrics and

Elder Abuse Facts

- Between July 1, 1991 and June 30, 1992 more than 12,450 elderly Ohioans were reported as having been abused, neglected or exploited
- 12% of victims were reported abused
- 10% were reported exploited
- 21% were reported neglected
- 57% suffered from self-neglect

emergency medicine.

The elder abuse campaign is funded by a \$50,000 grant from the Ohio Department of Human Services. ■

Ohio League Against Child Abuse closes

OHIO Medicine has learned that the Ohio League Against Child Abuse, also known as the Ohio Chapter, National Committee for the Prevention of Child Abuse, is folding this month because of financial difficulties.

The agency was listed as a resource in the educational handbook provided by OSMA in conjunction with the Ohio Physicians' Child Abuse Prevention Project.

As of this writing, officials at United Way were discussing the disbursement of funds and services to other agencies in town.

OHIO Medicine will keep you posted on further details. ■

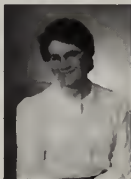
Colleagues

SALLY ABBOTT, MD, Springfield, was named Ohio's Family Physician of the Year by the Ohio Academy of Family Physicians. Dr. Abbott is co-founder and director of the family practice residency program conducted by Mercy, Community and Green Memorial hospitals.

ROBERT L. COITH, SR., MD, Cincinnati, received the Pauline Cohen Cancer Service Award from Cancer Family Care. Dr. Coith was honored because of his work in the area of breast cancer and his involvement with the Cancer Control Council.

THOMAS E. GRETTHER, MD, Pepper Pike, was reappointed to the state medical board by Gov. Voinovich. Dr. Gretter is a staff physician for the department of neurology and is associate director of professional affairs at the Cleveland Clinic Foundation.

ALICE A. GRICOSKI, MD, FACS, Gallipolis, was named cancer liaison physician for the Hospital Cancer Program at Holzer Medical Center in Gallipolis by the American College of Surgeons Commission on Cancer.



Dr.
Gricoski

WILLIAM J. HICKS, MD, Columbus, and **WILLIAM DAVID LEAK, MD**, Columbus, were reappointed to the Minority Health Commission by Gov. Voinovich. Dr. Hicks, associate medical director for Grant Medical Center, also maintains a private practice. Dr. Leak is medical director of Pain Control Consultants.

RALPH D. LACH, MD, FACC, FACP, Columbus, was appointed cardiology consultant to the United States Federal Air Surgeon. He is the founder of The Columbus Cardiology Clinic. He directs the adult cardiovascular fellowship training program and the cardiac care unit at Mount Carmel Medical Center.



Dr. Lach

ANDREW F. ROBBINS, JR., MD, Cincinnati, was installed as president and **SUSAN WEINBERG, MD**, Cincinnati, was installed president-elect of the Academy



Dr.
Robbins

of Medicine of Cincinnati. Dr. Robbins has a private practice in ophthalmology, chairs the section of ophthalmology at Good Samaritan Hospital and is a volunteer associate professor of family medicine at UC's College of Medicine. Dr. Weinberg, a radiologist at Bethesda North Hospital, is the

academy's first woman president-elect.

LAWRENCE J. YODLOWSKI, MD, Gallipolis, was elected president of the Central Ohio Urological Society. He is vice-president and a member of the medical staff of Holzer Clinic. ■



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OSMA In Action

A round-up of the association's activities...

■ Group practice membership activities

The OSMA Group Practice Advisory Task Force, along with the American Medical Association and the American Group Practice Association, will present a program November 12 from 9 a.m. to 4 p.m. at the Fawcett Center for Tomorrow in Columbus entitled "Physician-Hospital Integration: A Group Practice Perspective." The program will feature speakers from around the country addressing the procedural, legal and financial issues of group practices and their relationships with hospitals. For more information or registration, contact Jill Foley, OSMA's assistant director for group practice membership, at 1-(800) 766-OSMA.

■ Member fax newsletter

More than 1,200 members have signed up for the new fax newsletter, *Member Alert*. The fax newsletter was used to send late-breaking news to members regarding President Clinton's health-system reform plan. *Member Alert* will be faxed as often as necessary, to provide members with the latest health-care reform information. Physicians may still sign up to receive the free fax newsletter by completing and faxing the form found elsewhere in this issue.



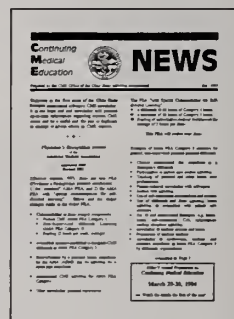
Physicians at a recent regional conference learn about OSMA's reform plan.

■ Regional conferences

Eight regional conferences, held last month to brief members on the report of OSMA's Task Force on Health-System Reform, were well attended, reports the Department of Medical Society and Member Relations. Members of the task force were at each of the conferences to present highlights of the report and answer questions (see the related front-page story for additional information). The OSMA has developed a videotape explaining the report of the OSMA Health-System Reform Task Force. Complimentary copies are available to county medical societies. Contact the OSMA Department of Communications for more information.

■ CME newsletters

OSMA's Department of Educational Services now produces two new quarterly publications: *CME Opportunities for Physicians* and *CME News*. The *Opportunities* list contains Category I programs through December 1994 and is sent to all OSMA members. According to Department Director Gail Dodson, the third and latest issue of the list contains more CME activities than ever before. If you didn't receive a copy and would like one, contact the OSMA Department of Educational Services at 1-(800) 766-OSMA. *CME News* features information regarding current CME issues. This is sent to all accredited providers of CME within the state, but if you'd like a copy, contact the Educational Services department at the number above.



■ Physician's Guide to Ohio Law

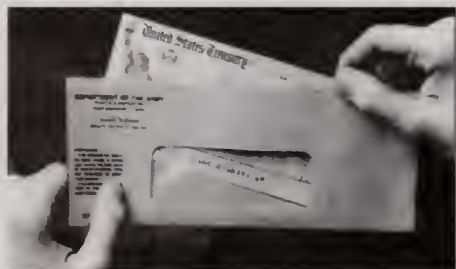
The 5th edition of the *Physician's Guide to Ohio Law* is still available from the OSMA Department of Legal Services. An order form was included in the September issue of *OHIO Medicine*. If you did not receive a copy and would like one, contact the Legal Department. The book is free to members.

■ Annual Meeting activities

You should have received your 1993 House of Delegates proceedings by now. If not, contact Susan Paulus in the Department of Educational Services at 1-(800) 766-OSMA. The 1994 Annual Meeting is scheduled for May 13-15 at Stouffer Tower City Plaza Hotel, Cleveland. The deadline for submitting resolutions is March 14, 1994. ■

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Search for health-care fraud intensifies

In Brief: Both the state and federal government are aggressively pursuing and prosecuting cases of fraud. Here are those that are most ripe for future action.

As the search for health-care reform funding gets under way, you can expect more attention to be paid to recouping those dollars lost each year in health-care fraud.

Consider these recent moves:

- Ohio Attorney General Lee Fisher has organized a Medicaid Health Care Fraud Section and Health Care Task Force.
- The U.S. Attorney General last year established the Southern District of Ohio Health Care Fraud Task Force.
- Nationwide Insurance has its own special investigation unit to combat insurance fraud.

As a result, cases that once slipped past prosecutors are unlikely to do so in the future. Law enforcement officials say that the following areas are those most likely to be prosecuted in the future.

- **Upcoding and unbundling:** Trying to increase reimbursement by manipulating billing codes on Medicare or private insurance claims forms. In "upcoding," a higher-paying code is given. In "unbundling," a single service is billed as a series of separate procedures.
- **Medical necessity:** In the past, prosecutors were unwilling to second-guess physicians on what is "medically necessary" and what isn't. Now, they are looking more closely at physicians whose orders for tests and procedures seem designed to run up bills.
- **Physician recruitment:** Some hospitals offer lucrative contracts to doctors, including guaranteed income and free rent in exchange for patient referrals. This generally violates federal anti-kickback laws – but there are a number of gray areas.

- **Self-referrals:** Medicare laws prohibit physicians from referring patients to laboratories in which they have a financial interest. Bills pending in Con-

gress extend the ban to facilities such as hospitals or radiology centers, and also cover private patients.

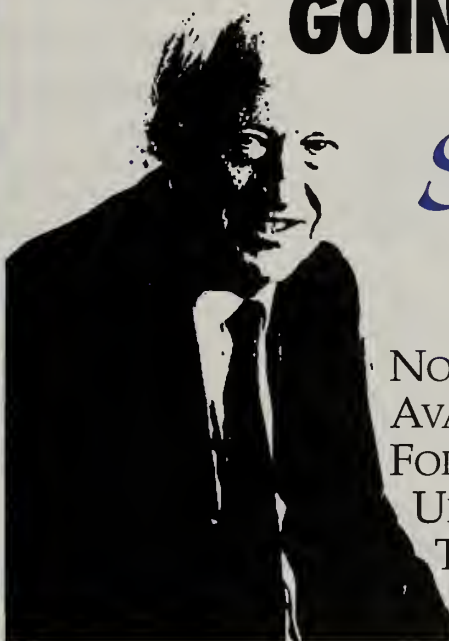
- **Limiting charge:** HCFA warns

physicians to comply with Medicare's limiting charges. ■

Part of the information for this story came from the Wall Street Journal.

The Merits of Membership:

"NOT BECAUSE YOU ARE GOING TO DIE, BUT, BECAUSE YOU ARE GOING TO SURVIVE."



Dr. Marius Barnard

Over a quarter of a century ago, renowned cardiologist, Marius Barnard assisted his brother Christiaan in performing the first human heart transplant. It was his realization that such a life saving medical advancement, while preserving life, created devastating financial impact on the surviving patients' struggle for recovery. Therefore, he created an insurance concept that allows critically ill patients and their families to have financial peace of mind even if their ability to support themselves is impaired.

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Physicians granted some safety from antitrust laws

The Federal Trade Commission and the Department of Justice have set up six "safety zones" – two specifically for physicians – where they will not challenge conduct under federal antitrust laws. Here are the two physician-specific zones:

INFORMATION COLLECTING

Generally the agencies won't challenge medical information that has been collected by physicians then provided to purchasers of medical services. For example, a medical society that collects outcome data about a particular procedure from its members, then provides that information to purchasers will be considered in the agencies' "safety zone."

Also unlikely to be challenged is

the development of practice parameters. However, the safety zone doesn't protect physicians who attempt to coerce compliance with fee recommendations, nor those physicians who collectively provide fee-related information to purchasers.

CERTAIN NETWORKS EXEMPT

What the agencies won't challenge: Networks with 20% or less of the physicians in each physician specialty. (If there are fewer than five physicians in a specialty in the market, the network may include one physician representing that specialty.) These physicians must have active hospital privileges, practice in the market and, most important, share substantial finan-

Six "safety zones" have been established – two specifically for physicians.

cial risk. Examples of substantial risk-sharing include an agreement to provide services to a health-plan at a capitated (or per-subscriber) rate, or financial incentives to achieve cost-containment. Those networks that don't meet these standards will be evaluated under the rule of reason: Either the physicians must share substantial financial risk or the venture enables

them to offer a new product that produces substantial efficiencies.

If you have questions, contact the OSMA's Department of Legal Services, 1-(800) 766-OSMA. ■

This article was adapted from information supplied by William Todd and Terri-Lynn Smiles of Squire, Sanders & Dempsey law firm.

The Shocking Truth About the New Tax Law Exposed!

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CALL NOW to get your copy of the report that can save you thousands.

Companies sell unnecessary posters

Physicians don't need to purchase those state and federal labor law posters being sold by various companies.

The OSMA Department of Legal Services has received dozens of calls from physicians who have been bombarded with literature from companies trying to sell the glossy posters, costing anywhere from \$13.95 to \$21.95.

The poster companies are advertising the products as "an insurance policy against government fines."

According to Nancy Gillette, attorney in OSMA's Department of Legal Services, physicians do not have to purchase these posters. However, you do need to post the information required by state and federal agencies in your office.

These requirements vary according to the type of procedures you perform in your office (i.e. lab tests, etc.) and the number of staff members you employ.

Once you've determined what postings you need to display in your office, the appropriate agency will provide you with a copy of the required posting upon request. However, the state and federal government is not responsible for notifying you of the need to post laws, nor will they automatically send you up-to-date posters.

The Legal section of the July issue of *OHIO Medicine* carried information on required postings. If you need more information about the law or have questions, contact the OSMA Department of Legal Services, 1-(800) 766-OSMA. ■

Families can collect on personal injury

The Ohio Supreme Court recently ruled that the family members of those involved in personal injury cases may recover damages for "loss of consortium," or the loss of the companionship of that individual – damages that, prior to the ruling, were only awarded to families in a wrongful death action.

"Now, families may claim separate damages for each child or parent affected by another family

member's injury or death," says Katrina English, director of OSMA's Department of Legal Services. The verdict is most likely to affect hospitals and insurers, but physicians could also be held liable if they are found to have caused the injury or death.

Juries and judges in personal injury cases will be allowed to assess the amount of the award, a sum that will be in addition to awards for actual damages. ■

Update

Appeals court reinstates nurse's suit

Physicians, beware of what you say in the operating room. The 2nd District Court of Appeals in Montgomery County has reinstated a two-year-old lawsuit filed by a surgical scrub nurse who accused a surgeon of slander and battery.

On Sept. 3, 1991, the scrub nurse, of Vandalia, claims that the surgeon grabbed her by the shoulder and forced her to within inches of a gangrenous gallbladder. She claims the physician berated her in front of the staff and accused her of sabotaging the operation.

Montgomery County Common Pleas Court Judge Erwin Kilpatrick ruled that Snyder had not proved "intent to injure" as required by law for battery, and that the physician's comments were not slanderous.

When the suit was reinstated, the higher court ruled that the surgeon did intend to commit an offensive contact against Snyder, and that some of his remarks could be considered slanderous.

Court rules Workers' Comp can drop docs

The Ohio Supreme Court has ruled that the Bureau of Workers' Comp acted legally when it decided that a Fairview Park physician should not be paid for treating injured workers.

Gerald Seltzer, MD, was dropped from the BWC program because he had been suspended from federal Medicare and Medicaid programs in 1983 for low-quality, unnecessary and harmful service. However, he continued to treat patients.

BWC believed that the state could suspend a physician who was suspended from the federal program.

The Franklin County Common Pleas Court said Dr. Seltzer had no right to appeal his suspension, however the Court of Appeals disagreed. The Supreme Court overruled the court, however, and reinstated the trial court's decision.

Physicians must now pay for NPDB self-queries

Physicians who want to check the National Practitioner Data Bank to see what data is stored on them will now have to pay \$10 if they're filing a paper claim, \$6 if they are filing electronically.

Free copies of all reports filed with the NPDB will still be sent to physicians at the time of filing, so practitioners will have the opportunity to note any problems at that time. However, they will now have

to pay if they wish to verify that the report was entered into the system accurately.

Physician may call the National Practitioner Data Bank's helpline at 1-(800) 767-6732. ■

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Legal Notes

In Brief: This column is condensed from the OSMA's legal fact sheet notebook. You may want to clip and save this column for reference. Questions should be referred to the OSMA's Department of Legal Services.

Duty to Report

CHILD ABUSE

Physicians are required to report known or suspected abuse of patients under the age of 18 or of mentally impaired patients under the age of 21. Oral or written reports should be made to the Children's Services Board, the County Department of Human Services or to a municipal or county peace officer.

Failure to report is a fourth-degree misdemeanor, which may result in a 30-day jail sentence and/or a fine of up to \$250.

The one exception to this requirement: If a minor patient tries to have an abortion without notifying her parents or guardian, the physician is not required to report suspected abuse.

ELDER ABUSE

Physicians are required to report known or suspected abuse of elderly patients to the county Department of Human Services. Failure to do so may result in a fine of up to \$500.

COMMUNICABLE DISEASE

Physicians are required to report diagnoses of cholera, plague, yellow fever, typhus fever, diphtheria or typhoid to the city or county health commissioner in the health district where the patient resides. Physicians are also required to report any infant with swelling, redness or inflammation of the eyes occurring within two weeks of birth. Failure to make these reports may result in a fine

of up to \$100 for the first offense. A second violation is a fourth-degree misdemeanor, which may result in a 30-day jail sentence and/or a fine of up to \$250.

OCCUPATIONAL DISEASE

A physician must report any patient suffering from poisoning from lead, phosphorus, arsenic, brass, wood alcohol or mercury or from any other occupational illness to the state Director of Health within 48 hours. Failure to do so may result in a fine of up to \$100.

CANCER AND AIDS

Physicians are required to report cases of cancer to the city or county health commissioner. Cases of AIDS must be reported to the

health commissioner of a health district designated by the state. These reports are made for statistical and research purposes only. Failure to report may result in a fine of up to \$100. A second violation is a fourth-degree misdemeanor, which may result in a 30-day jail sentence and/or a fine of up to \$250.

FELONIES

Physicians are required to report gunshot wounds, stab wounds, burn injuries or any injury resulting from a violent offense to the law enforcement authorities. Failure to do so may result in a 90-day jail sentence and/or a fine of up to \$750. ■



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HCFA's new policy cautions physicians who contract privately

In Brief: Despite the success of a recent New Jersey suit that determined there is no prohibition in Medicare laws and regulations against private contracting, HCFA's new policy outlines some definite "don'ts" for those who opt out.

BACKGROUND:

Last year, in *Stewart v. Sullivan*, a New Jersey doctor and five of her Medicaid patients sued HCFA, claiming it was a violation of their rights for the government to ban patients from contracting privately with a physician outside the Medicare program on a claim-by-claim basis.

CONDITIONAL SUPPORT:

The AMA and the Medical Society of New Jersey filed a joint amicus brief that supported the right to opt out of Medicare under three conditions:

- Physicians would be prohibited from charging a fee in excess of a reasonable fee, as stated in the code of medical ethics.
- Opt-out arrangements would be based on a full disclosure of all relevant information to the patient.
- A physician would not enter an opt-out arrangement with a Medicare beneficiary who is also poor.

COURT'S DECISION:

The case was dismissed after the judge said plaintiffs failed to establish that HCFA had a clear policy prohibiting private contracting. The AMA asked HCFA for a clarification of its policy on opting out by Part B beneficiaries.

NEW HCFA POLICY:

HCFA responded with a new section in the Medicare instructional Carriers Manual, Section 3044, which states:

- Nonparticipating physicians may not contract privately and charge a Medicare beneficiary more than the limiting charge.

- They must also submit a claim form to the Medicare carrier if the beneficiary is entitled to receive payment under Medicare Part B.

- Physicians who violate this policy will be subject to sanctions, including civil money penalties and/or exclusion from the Medicare program.

AMA RESPONSE:

The AMA continues to maintain that private contracting should be lawful under the conditions it has described. ■

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Managed care focus of task force

As national and state governments grapple with health-system reform, managed care appears to be playing a greater and greater role.

For that reason, the OSMA has

"We've been ignoring the tree and arguing about the ornaments."

formed a Task Force on Managed Care and charged it with monitoring managed-care plans as they develop and educating physicians, patients and legislators about the

various aspects of such plans.

At the committee's first meeting, held early last month, committee chair A. Robert Davies, MD, outlined the group's purpose as "scanning the horizon and telling physicians what's coming and advising Council as to what our position should be...I don't see us coming up with a reform plan."

Also, says Dr. Davies, the committee needs to take care in considering the big picture. "We've been ignoring the tree and arguing about the ornaments," he says.

"The tree is that the organization that pays the physician is going to be under even more strident pressure to deliver a package of care for a set price. Managed care will be tighter, tighter than it's ever been."

The committee has so far agreed



Members of the Task Force on Managed Care met recently to discuss their mission and plot their course.

that its major thrust will be the education of the patient and physician.

In addition to its main charge, the committee has tentatively decided to:

- Meet with officials of managed care, if needed, to discuss various issues.
- Develop physician educational materials and programs.

Other areas of possible consideration include:

- Participate in the development of a standard system of credentialing physicians for network participation.
- Review systems of physician referral to develop practical

guidelines for network physicians.

- Work with managed-care organizations to develop generic guidelines for a data base for physicians on their ability to work within a managed care program.
- Encourage local county medical society initiatives related to managed care.

But ultimately, the committee must first define and seek to understand managed care. "Managed care is the management applied to medical care, finance and delivery and accountability for all three," says Dr. Davies. "I don't think we've said that managed care is good or bad; right now we're just trying to define it." ■

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Medicare mailing disclosure forms

Nationwide-Medicare will soon be mailing physicians its annual Participation Enrollment Forms and Disclosure Reports.

Physicians who already participate in the Medicare program do not have to file new contracts; they will automatically be re-enrolled unless they indicate otherwise. Nonparticipating physicians who would like to participate, however, must send in their signed contracts (which are printed on bright pink paper) by **December 31**.

Physicians who choose not to

participate should know that as a result of House Bill 478, which passed the Ohio Legislature in December 1992, they may not balance bill a Medicare patient whose income is at or below 600% of the federal poverty level (\$41,800).

Nonparticipating physicians are reminded that limiting charge amounts may be no more than 115% of the nonparticipating fee schedule amount.

Physicians should receive Medicare's materials by the end of the month. ■

If you have questions about any story in the Third-Party Update section, contact the OSMA Ombudsman staff at 1-(800) 766-OSMA.

Carriers slowly phasing in new ICD-9 codes

Significant ICD-9 changes have been announced by HCFA, and although they became effective 10/1/93, individual insurance carriers, as well as Medicare, may not yet be prepared to accept them. To avoid claim delays or denials resulting from using codes the payor doesn't yet recognize, it's a good idea to call and ask when they will be accepting them.

This year's revisions appear in many different chapters of the ICD-9-CM code book. Below is an outline of these changes, which might help determine whether your specialty will be affected.

There were 151 new codes created. Some of them are brand new, while others were created by adding a fourth or fifth digit to an existing code. In addition, 31 existing code narratives were revised. All of these changes allow for greater diagnosis coding specificity. If you need more detailed information regarding these changes before purchasing your 1994 ICD-9-CM manual, please call the OSMAs Ombudsman Department (614) 486-2401 or 1-(800) 766-OSMA.

Physicians must have the up-to-date Fourth Edition. If you purchased the Fourth Edition (dated

Oct. '91) from the Superintendent of Documents, you will receive the new addenda at no extra cost, otherwise you may order Volumes 1 and 2 for \$65 by calling or writ-

ing: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954, or phone (202) 783-3238.

Orders for the ICD-9 books may

also be placed with the American Medical Association, 1-(800) 621-8335, and St. Anthony's Publications, 1-(800) 632-0123. ■

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Affected Codes

- 077-079 – Infectious and parasitic diseases
- 250 – Endocrine, nutritional and metabolic diseases, and immunity disorders
- 283 – Diseases of the blood and blood-forming organs
- 433-434, 440-441, 451 – Diseases of the circulatory system
- 530 – Diseases of the digestive system
- 704 – Disease of the musculoskeletal system and connective tissues
- 747 – Congenital anomalies
- 780, 788, 790 – Signs, symptoms, and ill-defined conditions
- 925-929, 995 – Injury and poisoning
- V codes – V codes

Guide answers third-party questions

Do you have a question about a third-party payor? Whether it concerns claim forms, reimbursement or medical necessity, the OSMA's Ombudsman Department's *Third-Party Desk Reference Guide* can help.

Offered to members free of charge, the reference guide includes valuable information and contact numbers for Blue Cross/

Blue Shield, Medicaid, Medicare, Peer Review Systems, Travelers-Railroad Medicare and Workers' Compensation.

To order a copy, clip and mail the form below to: OSMA, Ombudsman Department, 1500 Lake Shore Drive, Columbus, OH 43204-3824 or phone the Ombudsman at 1-(800) 766-OSMA. ■

Please send me the latest edition of the Ombudsman Department's *Third-Party Desk Reference Guide*.

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Mail this form to:
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Columbus, OH 43204-3824

Electronic billers gain a day

In an effort to reward physicians who bill electronically, the Health Care Financing Administration has reduced the payment floor to pay electronic Medicare claims from 14 to 13 days.

Also, the ceiling on interest has been changed to 30 days for all

claims received on or after October 1. Interest will be payable beginning the 31st day after the date of receipt. This applies to all assigned and nonassigned claims submitted electronically or on paper by participating or nonparticipating providers. ■

ODHS to accept HCFA-1500 form

Beginning next year, the Ohio Department of Human Services (ODHS) will begin to accept the HCFA-1500 claim form.

Health-care providers who bill the ODHS will be trained in the use of the HCFA-1500 form in two stages, the first of which will include physicians, podiatrists,

nurses and nurse/midwives.

Training, which will begin in January, will be provided by the Provider Relations Training Unit.

Registration forms and information regarding the training sessions will be mailed to individual providers by ODHS. ■

om•buds•man n, pl -men 1: a government official (as in Sweden or New Zealand) appointed to receive and investigate complaints made by individuals against abuses or capricious acts of public officials; 2: one that investigates reported complaints, reports findings and helps to achieve equitable settlements.

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Physician has high school stadium named for him

When athletes charge onto the field at Fairview High School, they'll be doing so at the newly named Dr. James B. Daley Stadium.



Dr. Daley

Recognition for service to his profession and community has been plentiful for Dr. Daley of Fairview Park, a suburb of Cleveland, but he received the ultimate compliment this summer when the Fairview Park Board of Education voted unanimously to name the Fairview High School athletic field after him.

The general surgeon has served previously on the Fairview Park Board of Education, including eight years as vice-president and 14 years on the Recreation Com-

mission - 10 years as chair. For more than 30 years, Dr. Daley took to the field with athletes at Fairview High School as their team physician.

"I was very surprised and very honored that they (the board of education) would think about me that way," Dr. Daley told a reporter from *West Life*, a suburban newspaper.

Back in 1982, Dr. Daley was named Ohio Outstanding Team Physician by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and the Ohio High School Athletic Association. In his nomination letter, a former principal of Fairview High School wrote, "Dr. Daley has become a friend of parents and students alike. He has given the highest quality of service to our young people free of charge."

Requests that the stadium be named for Dr. Daley came from his youngest son, Daniel; Dr. Frank



Fairview High School named its stadium after James B. Daley, MD, who served as its team physician for more than 30 years.

Barr, a former superintendent of Fairview Park Schools; and Richard Dunson, City Council president.

Besides being named Fairview Park Citizen of the Year in 1976, Dr. Daley has been presented with the Distinguished Service Award from the Cleveland Academy of Medicine. He received this honor in 1979 for his outstanding work in disaster planning for the Greater Cleveland area. He also organized and coordinated countywide plans

for handling medical problems that would arise in the event of a major disaster along with providing the groundwork for a statewide disaster network.

Even in his retirement, Dr. Daley continues to frequent athletic events at Fairview High School.

Dr. Daley was honored during halftime at a Fairview High School football game on Oct. 29. A reception followed in the high school cafeteria. ■

PHOs discussed at HMSS meeting

The key elements of successful physician/hospital organizations and the pros and cons of the Clinton-proposed health-care reform initiatives will be two of the topics discussed at this year's AMA-HMSS interim meeting, scheduled December 2-6 at the Hyatt Regency in New Orleans. Henry E. Golembsky, MD, director of Integrated Health Systems Practice, a division

of American Practices Management, will be the keynote speaker.

Other topics include: maintaining physician control in the credentialing of network providers, monitoring and assessment of patient care, and how to set quality-of-care standards and outcomes.

For more information about the program or the meeting, call (312) 464-4745 or 464-4761. ■

Toledo doctor writes of murder

Toledo radiologist Keith Wilson, MD, wondered what would happen if the residents of a small New Hampshire town developed a mysterious malady that eventually kills them - not in dramatic numbers within their town, but individually, when they travel away from it.

The result of his musings can be found in *Life Form*, a paperback novel published in August 1992 by Putnam Berkley Publishing. That book was followed quickly by *Cause of Death*, a non-fiction tech-

nical guide published by Writers Digest books that tells mystery writers everything they need to know about death, murder and forensic medicine. Dr. Wilson illustrated the book as well.

In a *Toledo Medicine* feature on Dr. Wilson, the author noted: "I'm not an accomplished writer. What I am is a published author. That's a start, but I have a lot I still want to achieve as a writer. It's not writing talent that sets me apart, it's tenacity. I just don't give up." ■

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KNOWLEDGEABLE

Oregon plan author notes problems with Clinton plan

In Brief: John Kitzhaber, MD, the author of the Oregon Health Plan, says that until a basic benefit package is explicitly defined, with input from physicians and society, the health-reform debate will rage on.

Ohio physicians are on the right track in developing a health-care reform plan they can take to the table, says John Kitzhaber, MD, author of the controversial Oregon health plan, which sets up a system of health-care rationing. Dr. Kitzhaber was the guest lecturer at this year's Fulton Memorial Seminar, held annually in Columbus.

"Physicians need to stop reacting to the proposed changes in health care and start leading," he says.

CONCERNS WITH CLINTON PLAN

Dr. Kitzhaber notes three concerns he has with the health-system reform plan recently offered by President Bill Clinton:

- There was no process of inclusion in developing the plan. Despite reports that various groups, including organized medicine, had input into the plan, no system was established that allows patients,

health-care providers or others to agree to what was included and what was not. Without that input the primary "stakeholders" in health reform have no ownership of the plan, and that's likely to hold up the process, as special interest groups zero in on those items they now want in or out of the reform proposal.

- There has never been an articulated objective. "Is it to provide health care for more people at lower costs?" asks Dr. Kitzhaber. "If so, that's impractical. First, it assumes that health care is synonymous with health and we know that's not true. In some cases, health care just prolongs dying." Second, it creates the illusion that all medical services are of equal value and effect – also not true.
- There is an unwillingness on the part of the administration to make the hard choices, specifically, what will be available in a basic benefit plan? "The comprehensive benefit package must be explicitly clarified or the debate will continue," Dr. Kitzhaber says.

The act of explicitly defining

"We can provide the services, but is society willing to pay for them?"

what goes into a basic benefit plan, however, implicitly defines what does not, and that creates the stumbling block of rationing health-care services.

Dr. Kitzhaber believes that providing that basic framework is, in part, the responsibility of the medical profession.

WHAT DOCTORS CAN DO

"Doctors need to bring their expertise to the table. They need to tell legislators what are clinically effective and appropriate services to include in a basic benefit package."

What is ultimately included in a benefit plan, however, is not a medical question, but a societal one, says Dr. Kitzhaber. "We can provide the services, but is society willing to pay for them?"

Without those decisions, without a framework that describes what will be covered and, implicitly, what will not, it will fall on physicians to limit access, and make

rationing decisions, an area where most physicians, legally and ethically, do not want to be.

STATE PLANS NOT USEFUL

Nor will a state-developed benefit package be useful, he continues. What happens when states with bigger budgets include more in their basic benefit package than other states? Will there be a migration of citizens away from one area, and toward another? "There has to be an over-arching framework for this benefit package," he says.

But the decision on what to put into that national framework should not fall on legislators, nor on plaintiff attorneys (which he says is inevitable without tort reform). What goes into a national benefit package should be the decision of physicians and their patients. "That's why physicians need to take a leadership role in health reform, but we need to do it now. The choice still remains with us." ■

Recruitment, Employment and Partnership Contracts; Hospital Bylaws, Credentialing and Privilege Issues; Medicare Fraud and Abuse Matters; High Risk or Uninsured Malpractice Exposures; Joint Venture Arrangements; CON Applications; Medicare, Medicaid and PRO (PRS, Inc.) Audits; State Medical Board Actions, Etc.

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Superdocs in the waiting room

No word as to whether or not copies of EnForce comic books have reached Ohio physician offices yet, but they may soon be "must-have" items for your waiting room.

EnForce books tell the story of a group of medical professionals who are attached to the fictional "California City General Hospital" where, during surgery one day, they are exposed to the energy radiated by the death throes of an alien being on their operating table. (Well, this is a fantasy industry.) Suddenly, the group discovers they have become a collection of "Superdocs," possessing powers and abilities far beyond those of mere mortal physicians.

Designed for 7- to 16-year-olds, the comic book is designed to "inspire confidence in the medical

EnForce comic books are "must-have" items for the waiting room.

professionals in whose reception areas patients will find the comic book," says Grant Fausey, one of the comic's two creators. Of course, it's likely that along with that increased confidence will come increased (and unrealistic) expectations. For more information, or to order, contact:

Reoccurring Images Publishing Group, 859 North Hollywood Way, Suite 422, Burbank, CA 91505. ■

The emergency surgery of President McKinley

Matthew D. Mann, MD, a prominent Buffalo gynecologist, was summoned September 6, 1901 to perform emergency abdominal surgery upon President William McKinley. He had been shot twice while welcoming visitors at the Pan American Exposition in Buffalo.

Examination of the president disclosed that the first bullet had caused only superficial injury to his upper chest. However, the second bullet had produced apparent intra-abdominal injury.

The operating room was lighted by one window.

The operating room was "a single room with no attached anteroom ...Surgeons scrubbed using basins set on a tabletop. The operating table was narrow of white enamel; a matching white enamel table used for instruments set along the one wall. The room was lighted by one window covered by thin muslin curtains."

The emergency hospital owned only a small number of instruments. It was common practice at this time for surgeons to carry their own instruments with them. While Dr. Mann did not carry his surgical bag to the barber shop, one of the assistant surgeons had fortunately brought his instruments with him. However, there was a lack of retractors, none being in the assistant's minor surgery bag.

The principle illumination of the operative field was sunlight. An assistant improved the situation by deflecting the light from the setting sun into the room with a hand mirror. Finally a single eight-watt electric bulb was acquired to assist with the surgical closing.

The patient was a stout man. His large abdominal girth resulted from the distribution of 200 pounds upon a 5'7" frame. At surgery the subcutaneous abdominal fatty layer measured 2-3 inches thick. Dr. Mann expressed his difficulty in... "working at the bottom of a deep hole."

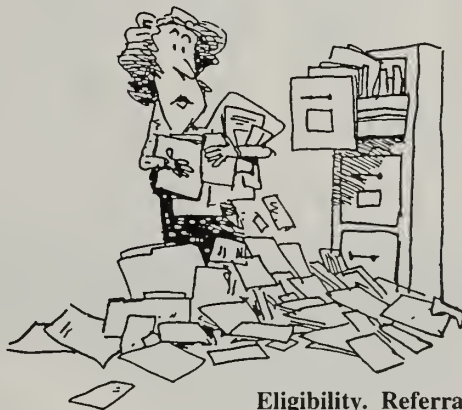
With McKinley under ether anesthesia, Dr. Mann completed

the operation in one hour 21 minutes. Exploration disclosed that the bullet had passed posteriorly, first through the anterior and then the posterior wall of the stomach. Both defects were closed with silk su-

tures. The peritoneum did not contain any gastric material, and the cavity was washed out with warm saline. Further search failed to reveal either other organ damage or the location of the bullet.

After an initial rally, President McKinley died on the eighth post-operative day. ■

Ludwig M. Deppisch, MD, is a Youngstown pathologist.



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Hospital challenges CON denial

Supporters of a cardiac catheterization lab at Columbus Community Hospital rallied at the Statehouse in late September in an attempt to persuade legislators to reverse the state health department's denial of

its application.

In an article in the *Columbus Dispatch*, Ohio Department of Health Director Peter Somani, MD, said: "The hospital is operating outside the legislative established

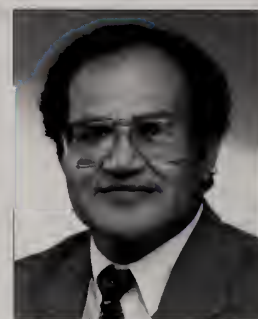
proposal review process and appeal system to obtain a cath lab. Certificate-of-need decisions are not made by referendum. Proposals are not approved solely on the basis of hospital or community wants or desires."

However, Bobby J. Meadows, Columbus Community Hospital

president, said:

"After the state denied the lab, South Side community leaders came to the hospital and said they wanted it made known to the community and public officials that the South Side has been overlooked." Columbus City Council is also urging approval of the lab.

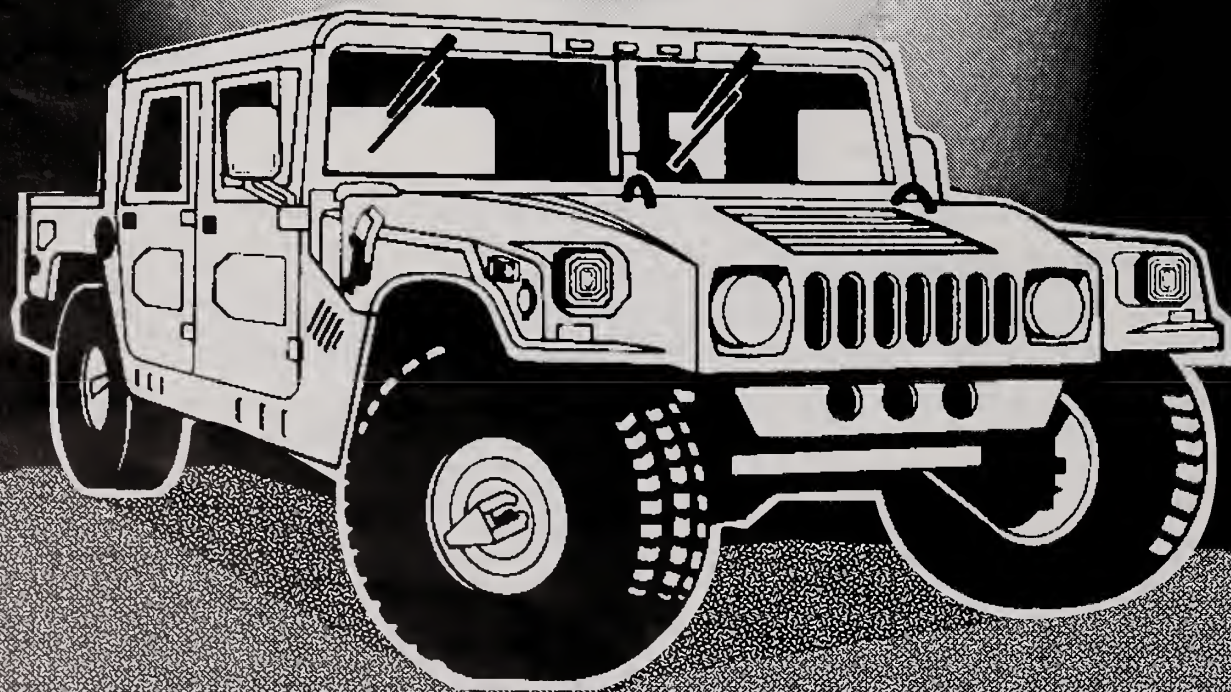
The health department's denial has been appealed to the state's Certificate-of-Need Review Board, which is expected to reach a decision later this month. ■



Dr. Somani

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For more information, contact Mary Jane Lautzenhiser, CMA, 931 U.S. 224, P.O. Box 41, Nova, OH 44859-0041. ■

PICO sells interest in company

The Physicians Insurance Company of Ohio recently received \$6.7 million for selling its 18% interest in The Winsbury Company Limited Partnership. PICO paid about \$32,000 for its interest in Winsbury during the mid-1980s.

John E. Albers, MD, PICO's chair, president and CEO, says: "Winsbury has been a profitable investment over the years for PICO," and that the sale will strengthen PICO's financial position. ■

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BORIS L. MARMOLYA, MD, Cleveland; State University of New York at Buffalo School of Medicine, Buffalo, NY, 1942; age 78; died September 6, 1993; member OSMa.

PAUL J. MCAFEE, MD, Portsmouth; University of Louisville School of Medicine, Louisville, KY, 1931; age 89; died August 23, 1993; member OSMa and AMA.

ROBERT P. PLOSSCOWE, MD, Amherst, NY; Faculte de Medecine de Universite de Lausanne, Lausanne, Switzerland, 1957; age 67; died August 14, 1993; member OSMa.

RALPH E. RASOR, JR., MD, Van Wert; Ohio State University College of Medicine, 1957; age 61; died August 11, 1993; member OSMa.

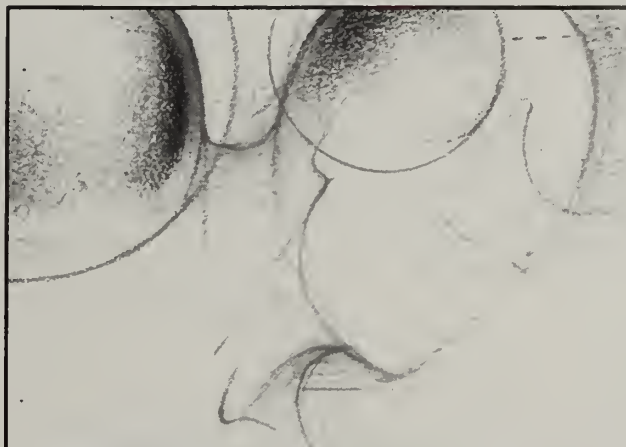
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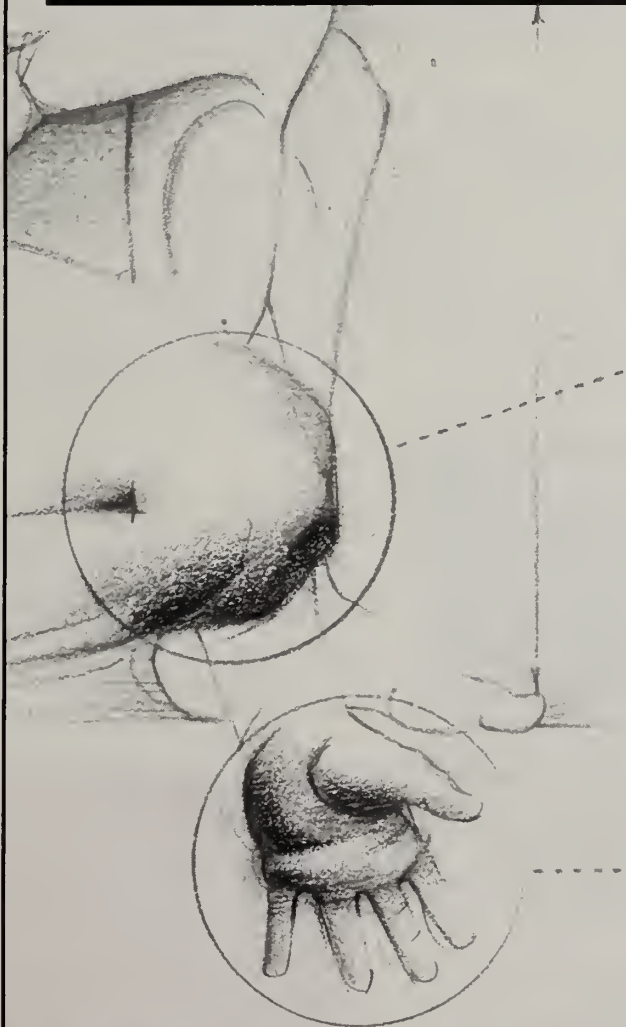
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ISABEL J. WOLFSTEIN, MD, Davis, CA; University of Michigan Medical School, Ann Arbor, MI, 1935; age 83; died August 17, 1993; member OSMa and AMA.

GEORGE D. WOODWARD, MD, Columbus; Ohio State University College of Medicine, 1928; age 94; died August 23, 1993; member OSMa and AMA. ■



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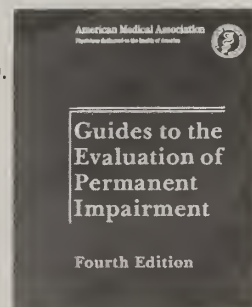
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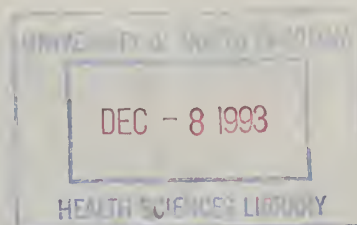
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News for Members of the Ohio State Medical Association

Employer mandate debated

OSMA presents reform plan to board

In Brief: The Ohio Health Care Board hears OSMA's reform proposals, but debates a mandate that employers provide coverage.

OSMA President Walter Reiling, Jr., MD took the association's proposal for health-care reform to the one group that may have the most influence on the future of health-care reform in Ohio.

Members of the Ohio Health Care Board took time during a recent meeting to listen to the recommendations set forth by "Shared Goals, Shared Responsibilities," the OSMA's plan calling for extending health-care coverage to all Ohioans.

"All of us share the goal of making quality health care available to everyone at an affordable price," Dr. Reiling told the board. "But reaching that goal will entail a high degree of cooperation and change on the part of everyone in the health system, including physicians. Our report reflects the fact that Ohio physicians stand ready to do their part to help make that



Photo by Jack Kustron

OSMA President Walter Reiling, Jr., MD, explains the association's plan for health-system reform to the Ohio Health Care Board.

goal a reality."

The board is currently debating one approach to extending coverage that's supported by many groups, including the OSMA: a mandate that employers should provide insurance for their em-

ployees. Some board members believe such a move won't result in lowered costs, but make it an employer's problem.

The board is expected to present its reform recommendations to the governor next month. ■

HCFA likely to implement statewide fee schedule

In Brief: After months of uncertainty and controversy, it appears at press time that HCFA will implement the request for a statewide Medicare fee schedule.

Ohio will convert to a statewide Medicare fee schedule next year, *OHIO Medicine* has unofficially learned from officials at the Health Care Financing Administration. This means all Ohio doctors will re-

ceive equal Medicare reimbursements rather than reimbursements based on pricing localities. The news was to appear officially in a late-November issue of the *Federal Register*. However, HCFA's decision to implement the OSMA's request for one statewide schedule has followed months of uncertainty and controversy.

BACKGROUND

At its 1992 Annual Meeting, the OSMA House of Delegates voted in favor of converting to a single statewide fee schedule, and immediately notified HCFA of its position.

HCFA, however, indicated that more proof of physician support

OSMA health-reform plan launched

In Brief: After presenting its proposal on health-system reform to Ohio physicians, the OSMA held a news conference last month to launch its "Shared Goals, Shared Responsibilities" report to the public.

The Ohio State Medical Association has officially gone public with its proposal for health-system reform. On November 9, OSMA President Walter Reiling, Jr., MD, released the association's proposal for health-system reform, "Shared Goals, Shared Responsibilities," to the public at a news conference attended by members of the media from around the state.

See HCFA page 3

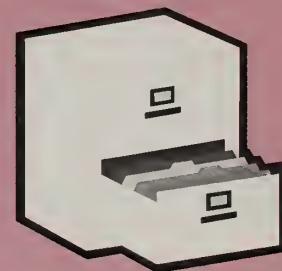
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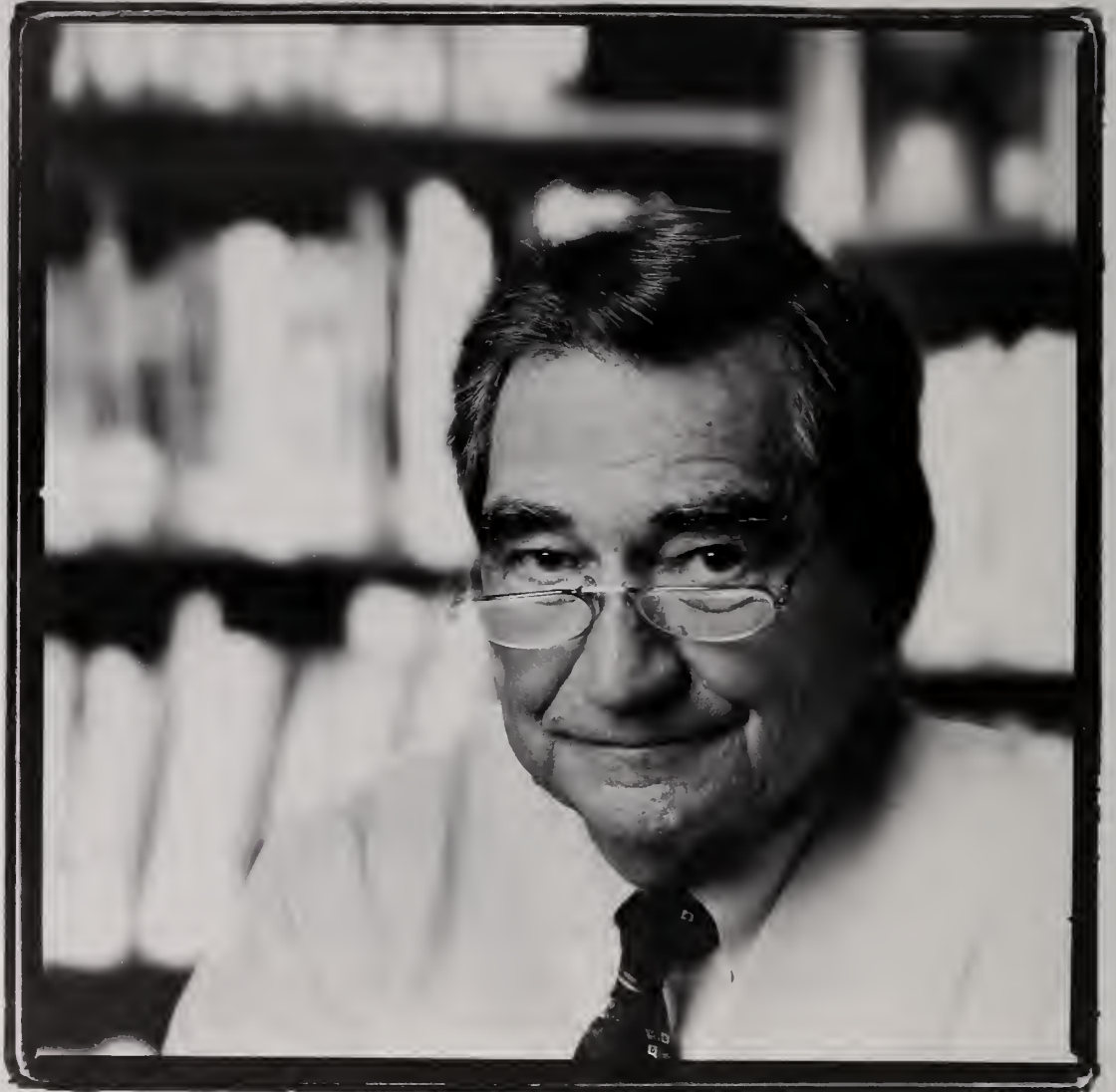
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"The intensity of the health-care debate going on around us is undeniable," Dr. Reiling told those in attendance. "The Ohio State Medical Association recognized the imperative need to provide Ohio policymakers with health-system reform options that place a primary emphasis on improving actual health-care delivery to Ohioans. This report, and the work of the OSMA Task Force on Health-System Reform leading up to it, represent an effort by Ohio physicians to participate in a meaningful fashion in the changing of our health-care system."

BASIC BENEFITS PACKAGE

Following his remarks, Mary Jo Welker, MD, a Columbus family physician who sits on the OSMA task force, and who also serves as the OSMA's Tenth District Councilor, presented a brief look at the OSMA's recommendations for a basic benefits plan.

Dr. Welker told reporters, "In putting together recommendations for what should be included in every health insurance plan, we tried very hard to balance the necessity of particular services or procedures against their cost."

Dr. Welker also indicated that consumers would still have the option of purchasing supplemental coverage that included services not contained in the essential benefits package. While preventive services are emphasized in the OSMA proposal, other services would continue to be covered by more extensive insurance packages.

Finally, OSMA President-Elect Claire Wolfe, MD, who also serves

as a member of the Ohio Health Care Board, told the media that the OSMA report would be presented to the Ohio Health Care Board for its review (see front page story).

DOCTORS CARE

Ultimately, however, the message that OSMA delivered to the media in November is that doctors are widely in favor of a change in our health-care delivery system (a recent OSMA poll found that 90% of Ohio doctors believe a significant change is needed), and that doctors care about how that change will affect patients. That's why the OSMA has become involved in the policymaking process. Dr. Reiling sums it up best:

"We are not, nor do we pretend to be, public policy experts. So we did not attempt to define our recommendations in minute detail. However, as physicians who work with our patients every day of the year, we have heard their concerns about the system. We believe that one of our responsibilities is to share that perspective with the policymakers who will be shaping health-care delivery in Ohio."

Both Drs. Reiling and Wolfe emphasized that the state of Ohio is likely to be given substantial leeway in developing a health system for Ohio. The OSMA hopes to work in a cooperative relationship with the Ohio Health Care Board and the Ohio Legislature in formulating the health-system changes implemented in Ohio.

The "Shared Goals, Shared Responsibilities" report was developed by a special OSMA Task Force on Health-System Reform.



OSMA President Walter Reiling, Jr., MD, addresses members of the news media at a press conference held to unveil the OSMA's health-reform proposal.

The task force was composed of 26 physicians from around the state, representing a wide range of practice types, specialties and practice

locations, a medical group manager and a representative of the Alliance. ■

Elements of OSMA's Public Message:

- Every Ohioan would be required to have health insurance.
- All employers would be required to provide health insurance.
- Most services would require some level of co-pay or co-insurance.
- Primary care and preventive services would be emphasized.
- A single relative value scale would be established for all physician services, but a physician would be free to determine his or her own annual dollar conversion factors and would publicize it to patients.
- Tort reform would be a top priority, with a cap on non-economic damages, a four-year statute of repose, and a limit on attorney contingency fees.
- A Commission on Health in Ohio would be established, with a clearly defined role.
- A tax on tobacco products and a surcharge on insurance premiums would be used to pay for expanding access.

HCFA...From page 1

was needed before making the change. Specifically, HCFA wanted assurances that physicians in the 15 counties that would receive lower reimbursement under a statewide schedule supported the conversion.

CONTROVERSY SPARKED

The OSMA contacted the 15 county medical societies where physicians stood to lose income under a statewide fee schedule. Of the 15 societies contacted, 11 indicated support of the statewide fee schedule, two expressed opposition, and two did not respond. The two counties in opposition to a

conversion represented only 35.5% of the losing physician members, yet when the OSMA notified HCFA of the low opposition rate in January, months passed before the association heard from HCFA, and then it was through the July 14 issue of the *Federal Register*.

The OSMA read that out of six states that had submitted formal petitions requesting a conversion, "only Ohio and North Carolina have demonstrated sufficient support from losing areas to support the change."

MORE WAITING

Still, HCFA was not prepared to

grant the request. Instead, through the *Federal Register*, HCFA solicited comment from Ohio physicians regarding the change. The OSMA alerted its members in August that letters of support for a statewide fee schedule needed to be sent to HCFA by September 13, and thousands of letters were sent in response. At the same time, one of the Ohio counties in opposition to the statewide fee schedule launched its own letter-writing campaign to HCFA, which may have contributed to the delay in HCFA's decision.

Finally, last month *OHIO Medicine* learned that HCFA would approve Ohio's request for a state-

wide Medicare fee schedule.

Ohio's 15 pricing regions for Medicare, based loosely on cost-of-living differences between urban and rural areas, will dissolve into one schedule next year.

"We're ready to implement the new statewide schedule," says Jim Cuppy of Nationwide Insurance, which operates the Medicare system in Ohio. "We don't foresee any problem in making the change."

Disclosure statements were mailed in late November. Physicians who have questions about the new statewide fee schedule should call the OSMA Ombudsman Department at 1-(800) 766-OSMA. ■

Ethics bill likely to affect OSMA's lobbying efforts

In Brief: As the result of a new ethics bill, doctors may have to improve their own grass-roots lobbying efforts with legislators.

Initiated in response to recent media reports critical of some legislators' ethics, House Bill 492 was rushed through the Ohio House in October. It now resides in a Senate committee.

If House Bill 492, otherwise known as the ethics reform bill, passes as expected, you may want to dust off your legislative directories and get to know your representatives on a first-name basis.

"As a result of this bill, physicians are going to have to do more grass-roots, one-to-one lobbying than they've ever done before," notes John Van Doorn, director of

OSMA's Department of Legislation.

The reason is simple. HB 492 significantly restricts certain Statehouse lobbying activities. Among other things, it:

- Bans honorariums
- Limits to no more than \$100 a year the total expenditure that can be spent on meals for legislators.
- Prohibits a legislator from voting on any bill supported by a special interest group that has made a campaign contribution of \$2,000 or more to that legislator.

"What this means is that the association may not be able to appeal

to the legislative leadership on health-care issues the way we used to," says Van Doorn. Instead, the OSMA will have to rely on physicians to lobby the 132-member Ohio General Assembly as the debate on health-system reform gains momentum.



If passed, HB 492 would restrict certain Statehouse lobbying activities.

FINANCE REFORM COMING

Meanwhile, another bill on campaign finance reform is also circulating in the Legislature.

"It's too early to tell what impact this bill will have on OMPAC since the issues are still being dealt with," says Van Doorn, but he adds

that changes will be made in OMPAC's structure, if necessary, to reflect those changes set forth by both the ethics and campaign finance reform legislation.

Watch future issues of *OHIO Medicine* for more news on these issues. ■

Discussions break down with nurses

Discussions between the OSMA and representatives of the Ohio Nurses Association on how to expand the nurses' scope of practice have been suspended for the time being, and no date has been scheduled for resuming the talks.

However, the association continues to work with physicians' assistants on shaping compromise legislation that would expand the scope of practice for PAs, while observing recent OSMA House of Delegates policy on this matter.

Amended Emergency Resolution 02-93, which passed at last year's Annual Meeting, requires the OSMA to oppose any legislation that would allow PAs to:

- Practice independently
- Be employed by hospitals or other institutions



OSMA President-Elect Claire Wolfe, MD, left, and Ohio Nurses Association representative Kathy Pepe, RN, at a past meeting of the OSMA-ONA liaison committee.

- Prescribe and dispense prescription medications
- Be licensed
- Be governed by an autonomous PA regulatory committee

"In accordance with this resolution, we are attempting, with the PAs, to shape legislation that will expand their ability to practice under the direction of a supervising physician," says John Van Doorn, director of OSMA's Department of Legislation. ■

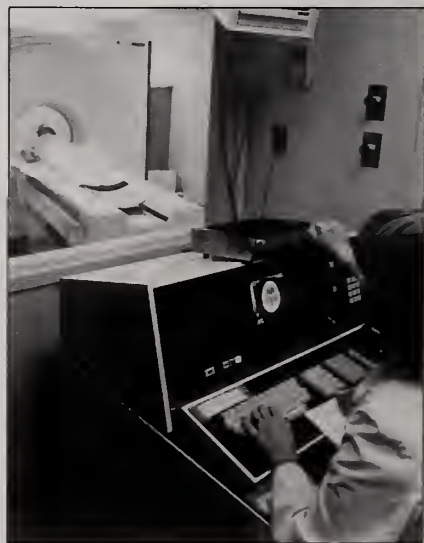
Radiation techs may need licenses

Senate Bill 191, which would provide for the licensing of radiographers, nuclear medicine technologists and dental assistant radiographers, remains, for the time being, in the Senate Health and Human Services Committee, but if passed, it may have an adverse effect on general practitioners and others who have and use X-ray equipment in their offices.

As reported in last month's *OHIO Medicine*, SB 191 was introduced by Sen. Grace Drake (R-Solon).

"If the bill passes, the doctor will have to send his or her unlicensed technicians for training or they will have to hire licensed technicians," says Cynthia Snyder, associate director of OSMA's Department of Legislation. "A third alternative is that the doctors will have to operate the equipment themselves."

The bill, of course, is opposed by family and general practitioners, especially those in underserved areas who operate their own radiology equipment for the convenience of their patients. But because



Nuclear medicine technologists, radiographers and other radiology technicians may soon be licensed.

the Ohio State Radiological Society supports the bill, the OSMA is remaining neutral on this issue, although legislative staff members are actively monitoring its progress. Watch *OHIO Medicine* for news on the outcome of Senate Bill 191. ■

Bill would license, regulate utilization review agents

After introducing legislation to license an assortment of limited practitioners (see boxed story at right), Rep. Wayne Jones (D-Cuyahoga Falls) has now drafted a licensing bill the OSMA can support.

House Bill 526 would require the Ohio Department of Insurance to license and regulate internal and external utilization review agents, and require them to:

- Provide physicians and policyholders with a toll-free phone number so that adverse deci-

sions can be appealed.

- Respond within two business days to any appeal made in writing or on the toll-free telephone line.
- Provide to physicians and policyholders the utilization review criteria used to judge and deny care, and
- Provide physicians and policyholders with a written description of the appeals process.

The bill would also make the UR

agent liable, along with the provider, for any personal injury that results when care is denied. Further, it would prohibit the agent from basing compensation on "bounties," or the amount of money that is saved when care is denied.

"We can expect the insurance industry and HMOs to fight this legislation," says John Van Doorn, director of OSMA's Department of Legislation. "And while the OSMA has no formal policy yet on this bill, it's expected that we'll support it." ■

Choice-of-pharmacist bill altered

Last month, *OHIO Medicine* reported that an unacceptable substantive change was being made to Senate Bill



Rep. Boggs

212, originally introduced to correct technical flaws in the recently passed Workers' Compensation reform bill.

A provision had been added in the Senate granting enrollees in the bureau's managed-care plan the freedom to choose a pharmacist, but not their personal physicians. It appears, however, that the measure may have been stopped in the House.

Rep. Ross Boggs (D-Andover), who chairs the House Commerce and Labor Committee, has offered

Update

a new corrective bill to legislators that deletes all substantive changes to the original bill, including the provision described above.

"Both bills will probably go to a conference committee," says John Van Doorn, director of OSMA's Department of Legislation.

A letter sent by the OSMA to Rep. Boggs and committee members points out that the association is reluctant to take a position against a patient's right to choose a pharmacist. "We believe, however, that a patient's right to choose a physician is far more important, and if the pharmacists' provision is to remain in the bill, then freedom to select your physician should be included," says Van Doorn.

OHIO Medicine will continue to provide updates on this matter. ■

Bills license counselors, therapists

Last month, *OHIO Medicine* reported that Rep. Wayne Jones (D-Cuyahoga Falls) had introduced House Bill 498 permitting physical therapists to practice independently. The bill repeals the requirement that physical therapy can be provided only with a prescription or upon referral.

Now, Rep. Jones has introduced two new bills that would license more limited practitioners. House

Bill 523 would license and permit professional counselors to diagnose and treat mental and emotional disorders that are now only treated by psychiatrists and psychologists.

And House Bill 529 would license and regulate hypnotherapists. That bill also requires those who use investigative hypnosis to complete training in that subject. ■

Official White House photo



Past President Meets First Lady

Last month, *OHIO Medicine* carried Dr. John Devany's article, "My Meeting With Hillary Clinton." Here he is shown shaking hands with the First Lady after their meeting this past fall.

Lawsuits target reform bill

The constitutionality of a Workers' Compensation Reform bill that passed this summer has been challenged in the Ohio Supreme Court by three lawsuits, filed by the United Auto Workers, the Ohio AFL-CIO and Richard Geltzer, a member of the Ohio Industrial Commission.

The lawsuits ask the court to overturn the new law and keep the system running under the current laws because the bill did not receive the required number of readings outlined by the state constitution. *OHIO Medicine* will notify you of the court's decision as soon as possible. ■

OSMA has concerns about "any willing provider" concept

In Brief: Although legislation has yet to be introduced, the OSMA Council – after much discussion – has decided to support "any willing provider" legislation being drafted by Rep. Michael Fox.

Rep. Michael Fox (R-Hamilton) and Rep. Otto Beatty (D-Columbus) are drafting legislation that, if passed, would force insurers to accept in its health-care plans any provider who is willing to comply with the plan's policies.

After much debate at the OSMA Council meeting in November, the association has decided to support the legislation, but there will be a number of caveats attached to that support.

At present, insurance plans may dismiss any physician without cause and with no explanation of the reasons for dismissal.

REASONS FOR SUPPORT

On the surface, the legislation appears to offer Ohio physicians a fair and equal opportunity to participate in the health-care plans that are being created rapidly by the insurance industry. In large part, these plans are a response to re-

form proposals that call for increased "managed competition" as a way to control health-care costs.

At present, however, insurance plans may dismiss any physician from these plans without cause, and with no explanation of the reasons for dismissal – a situation that many physicians think is unfair. In fact, members of both OSMA's Task Force on Managed Care and Workers' Compensation are in favor of the concept of "any willing provider" legislation.

"The mood of Ohio physicians is that insurance companies don't have the right to drop them from their plans," says John Van Doorn, director of OSMA's Department of Legislation.

Yet legislation mandating insurers to accept any provider who wants to practice in their plan is not without drawbacks.

DRAWBACKS TO CONCEPT

First, the legislation does not read "any willing physician," but, instead, "any willing provider," which means that by supporting the legislation, the OSMA also endorses the concept of allowing groups such as chiropractors, optometrists, nurses and other limited practitioners into these plans. Second, by mandating that all insurers must accept any and all providers, it's conceivable that providers may, in turn, be forced to deal with all payors, including Medicaid.

Some Councilors at the November meeting also raised the question as to whether or not all physicians should be allowed into every health-care plan. If that's the case, they noted, then there is no more competition, and the state may as well convert to a single-payor system.

LEGISLATIVE OPPONENTS

"The insurance industry obviously will oppose this legislation," says Van Doorn.

So might the Ohio Health Care Board. According to Claire Wolfe, MD, OSMA's president-elect and the provider representative on the Ohio Health Care Board, that group "seems to be working toward the goal that all physicians must be board-certified."

"The payors are seeking accreditation to keep their market share, and the accrediting agencies, like the National Quality Assurance Board, are requesting board-certification," she explains. It's possible, then, that board-certification could become an issue in the state legislative debate.

NEGOTIATING ROOM

Although a neutral stance might seem the best position the OSMA could take on this bill considering both the benefits and drawbacks, Councilors decided to openly support the bill, despite their concerns. At least, they noted, this position would give them a seat at the negotiating table, which a neutral stance would fail to do. The idea, however, is for the OSMA to go to legislators with a list of concerns, specifically the need to limit the legislation to physicians rather than all providers, although that may not be a realistic legislative goal, Councilors noted.

Dr. Reiling has charged members of OSMA's Task Force on Managed Care and Workers' Comp to arrive at the list of caveats, which the OSMA will take to legislators.

At press time, Rep. Fox had not yet introduced his legislation, but *OHIO Medicine* will follow this issue closely in the months ahead.

Watch future issues for the official wording of the bill and the specific concerns that the OSMA will address with legislators. ■

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J. Stephen Teetor is a former counsel to the Ohio State Medical Board and has served as an Administrative Law Hearing Officer for State professional licensing agencies.

Douglas C. Boatright is a former Assistant Attorney General who represented the Ohio State Medical Board, Ohio State Dental Board, the Chiropractic Board of Examiners and the Speech Pathology and Audiology Board in enforcing the statutes and regulations governing those professions and has also served as an Administrative Law Hearing Officer. Mr. Boatright is also a Registered Respiratory Therapist.

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If you have questions about any story in the Legislation section, contact the OSMA Department of Legislation at 1-(800) 766-OSMA.

OSMA health-reform task force produces video

Members of the OSMA's Task Force on Health-System Reform have put together a 20-minute video that explains the reasons behind the recommendations contained in their report, "Shared Goals, Shared Responsibilities."

Walter Reiling, Jr., MD, OSMA's president and task force chair, along with several other task force members, speaks candidly on the tape about changing Ohio's health-care system. He emphasizes that physicians need to be part of the process. "Our reform proposals were not reached easily and will not be implemented without some pain in the medical community," he says. Dr. Reiling talks about the

shared goals and responsibilities needed to make these changes occur. Yet he and the task force are aware that more compromise will be necessary when the plan is submitted to legislators and government agencies such as the Ohio Health Care Board. (See front page story for additional information.)

To arrive at their recommendations, the 28-member task force met all day, every third Saturday, for six months. They listened as outside experts presented model plans. They spent hours reading materials, and debating what would be good for Ohioans. The final proposal was a consensus – no one task force member was 100%

pleased with every element of the plan.

The video, like the report, received favorable response from those attending the eight regional meetings the OSMA sponsored.

In early November, OSMA's Department of Communications notified all county medical society presidents, specialty societies and chiefs of staff that the video was available and offered them a complimentary copy. This notice included an offer to have a task force member or other OSMA representative speak at upcoming medical meetings.

Any OSMA member can borrow a copy of the video to show at com-



munity meetings or other speaking engagements. Contact the OSMA Department of Communications at 1-(800) 766-OSMA if interested.

Plans are in the works to put the video on audiotape, which will be made available to members. *OHIO Medicine* will keep you posted on when the audiotape is available. ■

Ohio's Rep. Hobson backs bipartisan health plan

U.S. Rep. David Hobson (R-Springfield) has joined a bipartisan group, spearheaded by Rep. Jim Cooper (D-Tenn.) and Rep. Fred Grandy (R-Iowa) in supporting a managed competition plan different from those offered by President Bill Clinton and the Republicans.

Rep. Hobson recently presented the plan in Columbus at a health-care reform meeting, sponsored by the Ohio Hospital Association.

The plan:

- Does not require employers to



provide coverage

- Does not allow insurers to choose "best-risk" customers

- Sets up a purchasing cooperative to bargain for affordable rates
- Reforms Medicaid

Rep. Hobson says the plan would cost about \$40 billion in new federal spending over five years. However, the bipartisan proposal does not provide coverage for everyone, although universal access is attempted by providing low-income people with subsidies to buy insurance.

The bipartisan plan, says Rep. Hobson, is neither too liberal nor too conservative.

"Our plan is squarely in the middle, where it should be," he says. ■

Medicaid waiver gets support of health-care board

The Ohio Health Care Board (OHCBC) has voted to support the Medicaid waiver program, which was announced by Gov. George Voinovich early this fall and was featured in an *OHIO Medicine* story last month.

The program would allow Ohio to expand the Medicaid program to cover the 1.3 million Ohioans who are currently without health-care coverage.

OHCBC member Arnold Tompkins, director of the Ohio Department of Human Services,

was told to proceed with the waiver process. This involves assembling the proposed waiver and presenting it to the Health Care Financing Administration within 45 days. A target date for the completion of this process has been set as the end of the year.

The plan establishes a "purchasing pool" of patients, which would spark competition among health-care providers, which in turn would allow the state to negotiate lower costs for services. No new state or federal funds would be



AT THE STATE HOUSE

required.

If Ohio receives a waiver, the plan would be implemented over the next five or six years. ■

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PRESIDENT'S PERSPECTIVES

The "any willing provider" controversy

Recently, several of the larger managed-care programs in Ohio have begun dismissing significant numbers of their physician providers "without cause" as allowed in their contracts. Also, there is concern that many managed-care programs are becoming highly selective, even discriminatory in their selection criteria for new or additional physician providers. Given the market penetration these entities now enjoy, coupled with their rapid growth, it is no wonder there is apprehension and anxiety in the physician community.

Many physicians, particularly those who feel most threatened by these activities, have seized upon the "any willing provider" concept as an immediate and perhaps ultimate solution to their problem(s). The concept is simple: introduce and have passed a state statute that requires all managed-care programs to accept as a provider anyone who meets basic qualifications and is willing to agree to abide by the contractual requirements of the managed-care program.

Seems simple and sounds good – or is it? Actually, the whole issue is rather complex, and not as clear as it seems.

Three interrelated issues must be analyzed carefully before one jumps on the bandwagon.

1.) CONTRACTS

Few physicians actually read the contracts they sign and fewer still

take the time to have them reviewed by competent attorneys or by OSMA's Third-Party Payor Contract Analysis service. If you sign a contract with a "termination without cause" clause, you've signed away any right to an explanation, hearing or appeal. A recent court case, brought by Montgomery County physicians, served only to prove that point. In a perverse sense, under alleged deviations in quality of care standards, that clause and the lack of a due process hearing may shield the terminated physician from being reported to the National Practitioner Data Bank.

However, I believe the reason most physicians are terminated is for economic reasons. What is needed here is state legislation allowing the terminated physician due process if he or she requests it. The OSMA passed a resolution supporting legislation requiring due process prior to dismissal at its 1993 Annual Meeting.

2.) "ANY WILLING PROVIDER"

On the surface, passage of such legislation seems a motherhood-and-apple-pie issue, but in the eyes of state legislators, the term "provider" is not restricted to physicians, but also includes almost all limited license and alternate-care providers, perhaps encompassing optometrists, chiropractors, psychologists, social workers, podiatrists, physical therapists and most

others who wish to provide services within a managed-care system. Further, it is politically difficult to limit the definition of provider to physicians only.

A potential problem also exists at the opposite extreme. Remember, we stated physicians would have to meet certain criteria and agree to certain regulations. Should this legislation be adopted, I believe we can fully anticipate that managed care will immediately respond with very restrictive admission criteria and potentially impossible regulatory requirements.

3.) FAIRNESS ISSUES

Even though there is little sympathy for marketing problems of managed-care entities within the physician community, we must realize the passage of such a statute may well impose an overwhelming burden on some plans, and will certainly raise costs for all. Credentialing of physician providers is both necessary and costly. Does a managed-care entity with 10,000 subscribers need 1,000 physician providers? Should a small multi-specialty physician group, which also happens to have its own well-functioning HMO, be required to admit numerous and perhaps unknown physicians? The passage of this legislation could cause the demise of several small physician-

Walter A. Reiling, Jr., MD



oriented and physician-friendly managed-care programs.

Many physicians within the OSMA have requested that our organization endorse such legislation, while others have promulgated the rumor that the OSMA officially opposes such a stance. The latter statement is simply false. In fact, until the OSMA Council meeting of November 6, the OSMA had no official position. At that meeting, with the knowledge that Reps. Michael Fox (R-Hamilton) and Otto Beatty (D-Columbus) intend to introduce such legislation, the Council discussed the matter. After a spirited debate, the concept of "any willing provider" legislation was endorsed. At the same time, Council listed a number of concerns with the draft proposal, which will also be sent to appropriate legislators.

This is not, from our perspective, a final decision on this issue. It must be watched and has at least the potential of causing all of us considerable difficulty before a bill is delivered to the governor. ■

ALLIANCE REPORT

AMA-ERF: A tradition of caring

Rosemary Kuster Taylor remembers precisely the moment when her personal dream came true and she was offered the opportunity to attend nursing school. Her opportunity came in 1948 via the Licking County Medical Society and Medical Auxiliary when they sponsored their first nurse scholarship program.

I had the privilege of meeting Rosemary this summer at a community social function. What a pleasure to hear about her 45 years of nursing experience. Rosemary has continually worked as a nurse and is thankful for a career that has helped support her family, a career in which she found continual advancement – all due to a scholar-

ship provided by members of our medical organization. Many of our county alliances still support medical education through scholarships.

The American Medical Association Education Research Foundation was established 40 years ago to support our medical schools.

Last year, contributions were almost \$2.5 million. We need your

help to not only meet this figure but surpass it. The message is "One Choice: One Hour." One hour of medical education costs \$21.30. Won't you please support your local medical education scholarship programs through your medical society or alliance/auxiliary? ■

—Valerie Vollmer, President

May We Have A Moment of Your Time?

In order to better determine the reading tastes of our member physicians, we have included this brief questionnaire on *OHIO Medicine*. We would appreciate your answers, as well as your comments. This information will help us improve the editorial quality of *OHIO Medicine* in 1994. Please fax your comments to: Karen Edwards, Executive Editor, *OHIO Medicine*, (614) 486-3130 (make certain that you fax both sides of the form) or mail them to 1500 Lake Shore Dr., Columbus, Ohio 43204-3824. Thank you for your help.

1. The past few months, *OHIO Medicine* has devoted much space to reporting on health-system reform. In 1994, would you like to see this coverage changed?

• National health reform _____ Expand _____ Reduce _____ Same
• State health reform _____ Expand _____ Reduce _____ Same
• OSMA-sponsored health reform _____ Expand _____ Reduce _____ Same

2. *OHIO Medicine* features four regular departments each month. Please indicate whether any of these departments should be changed in 1994.

• Legislation _____ Expand _____ Reduce _____ Same
• Association _____ Expand _____ Reduce _____ Same
• Legal _____ Expand _____ Reduce _____ Same
• Third Party _____ Expand _____ Reduce _____ Same

3. Which topics would you like to see more coverage of in 1994?

_____ Activities of Ohio Health Care Board
_____ Activities of Ohio State Medical Board
_____ Group practice
_____ Managed care news
_____ Association news
_____ News from county societies
_____ News from medical schools
_____ National health news
_____ Other (please identify)

4. What topics would you like less coverage of in 1994? Please specify.

5. What type of articles do you favor? (Prioritize if more than one)

_____ Question-and-answer stories/interviews
_____ Short news stories, basic facts only
_____ Longer news stories with more information
_____ Feature length stories (1-2 tabloid pages)
_____ Mix of above

- Over -

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

1. *Journal of the American Medical Association*, 1997; 277: 103-107.
 2. *Journal of the American Medical Association*, 1997; 277: 108-112.
 3. *Journal of the American Medical Association*, 1997; 277: 113-117.
 4. *Journal of the American Medical Association*, 1997; 277: 118-122.
 5. *Journal of the American Medical Association*, 1997; 277: 123-127.

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LETTERS TO THE EDITOR

Describe board's disciplinary actions

To the Editor:

In the Legal section of the October issue of *OHIO Medicine*, an article written by Dr. Anand Garg and Joan Wehrle of the Ohio State Medical Board described disciplinary actions taken for prescribing drugs.

In order to make this article clearer to those of us who are not attorneys, perhaps you could define some of the statements made in that article. For example:

- What does "stayed revocation" mean?
- In Case #4, the violation was "Found guilty of second-degree misdemeanor (illegal dispensing of drug samples)." Would you please explain the board action in more detail? (The paragraph read: Reprimanded, doctor required to notify all employers and chiefs of staff of consent agreement/reprimand.)
- In Case #5, "improper disposal of controlled substances and adulterated drugs," please define that better so the majority of physicians can better appreciate the problem.

MORTON GROSSMAN, JR., MD
Lyndhurst

Lauren Lubow, JD, of the Ohio State Medical Board, responds to Dr. Grossman's questions:

- Permanent revocation of a physician's license is the sternest disciplinary measure the State Medical Board can impose. In some instances, the board may order that a license be revoked, but refrain from imposing the revocation provided that the physician complies with all remaining required terms of the order. A revocation that has been put on hold in this manner is considered to be "stayed." If the physician violates the board's order before all of its terms have been satisfied, the stay is removed and the physician's license is permanently revoked.
- In Case #4, the physician involved was charged by the medical board after he was found guilty of illegal dispensing of drug samples, a second-degree misdemeanor. The physician admitted that he had committed the acts that led to the conviction. In lieu of a hearing, the physician entered into a consent agreement with the board that incorporated both his admission and the sanction, a reprimand. The agreement included a standard requirement that the physician provide copies to all employers and the chief of staff at each hospital where he has, applies for, or obtains privileges in order to keep them apprised of pertinent public information.
- In Case #5, the medical board indefinitely suspended the physician's

license after he disposed of controlled substances and adulterated drugs in open trash bins accessible to the general public. Under Ohio law, a dangerous drug is adulterated if its stated expiration date has passed or if it has not been properly stored according to the manufacturer's literature. Physicians should contact the State Board of Pharmacy at (614) 466-4143 for information about proper disposal of outdated or contaminated drugs or of any controlled substance.

The trouble with statistics

To the Editor:

Your article in the October issue reporting on lack of primary health services in Ohio and the accompanying map fail to account for one further factor; that is, the standard method for collection of statistics fails to account for factors beyond the actual number of physicians per county.

Of the nine physicians that I am aware of in our county, eight are in active practice, and one is practicing only part time. I know that at least one of the other physicians plans to retire soon. Half of the physicians are over 50 years of age. Given the likelihood in rural areas of every night or every other night on call, and the potential lower reimbursements, we find it extremely difficult to recruit physicians to our rural community.

Finally, as many of my gynecological patients have told me, it is very difficult, if not impossible, to locate a family physician in our county. Physicians currently in practice have very busy and full schedules, and are not taking new patients as a rule, regardless of payment source.

When one considers these factors, all of a sudden it looks as if Wyandot County indeed does have a physician shortage. I'm sure that we are not the only county in this situation. Statistics can tell us many things, but in this particular instance, the Ohio physician shortage area map that you show doesn't tell enough of the story, especially to those in positions of power. Until this situation is rectified, we can only expect availability of medical care in rural areas to continue to decrease.

PHILLIP P. SMITH, MD, FACOG
Sycamore

Viewpoint

50 years of hyperactivity

Dr. Charles Bradley, more than 50 years ago, reasoned that if sedatives made hyperactive children worse, stimulants might improve them. He was right! So, today, there are over 600,000 children receiving Ritalin, cyclert or dextro-drine.

These drugs decrease restlessness, impulsivity, inattention and distractibility so that children, as

well as some adults, learn and function better. Addiction does not occur, and any minor side effects disappear as soon as the medicine is stopped.

Do you know of any drug with a better record? (See related story on page 21.)

W.B. Rogers, MD
Cuyahoga Falls

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SECOND OPINION

The inequities of rural obstetrical care

By Phillip P. Smith, MD

Dr. Gregory Bergman's letter in the October issue of *OHIO Medicine* touches on a very important point that is often overlooked regarding family physicians in the practice of obstetrics.

In situations in which the family physician is acting as the obstetrician, he or she may end up providing all of the prenatal care and sitting with the patient throughout a long labor, only to call in an obstetrician or general surgeon late in the game to provide caesarean section services. It seems there is no way to reimburse a family physician for his or her skills, time and medical/legal risk taken without resorting to fee-splitting. Of course, if we were lawyers, this would not be objectionable, but as physicians, we tend to hold this type of behav-

ior as unethical if not outright illegal.

As an OB-GYN in a rural area, I would very much like to see family physicians and midwives providing more obstetrical services. The majority of my obstetrical patients are low-risk patients, and could be very well served by a family physician. I should think that the inequities and the current payment schemes, whether by private insurers or government payors, at least in part acts as a disincentive for family physicians to enter the practice of obstetrics.

I have suggested to Ohio Medicaid's Perinatal Advisory Committee that a payment scheme be devised that, in these situations, would more equitably distribute payment. Certainly, as the obstetrician who walks in at the last minute and does a caesarean sec-

tion for the family physician who has toiled with the patient, I only think it fair that the family physician take the lion's share of the payment.

To think that any payor would regard \$520 as fair reimbursement for provisions of obstetrical services, even without actual performance of the caesarean delivery is ludicrous. Current payment rates probably don't compensate any of us adequately for the time, skill and medical/legal liability that we incur by providing obstetrical services. Whether these services are provided by nurse/midwives, family practitioners, or obstetricians/gynecologists, any future plan of health-care reform is going to have to acknowledge that, as long as the lawyers rule the roost in this country, providers of obstetrical services will have to be well-



Dr. Smith with two of his patients.

compensated for their efforts, regardless of their role. ■

Phillip P. Smith, MD is an OB-GYN who practices in Sycamore.



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Integration of practices changing face of health care

In Brief: Merging your practice may be one way to preserve a physician's place in the health-care delivery system. Before taking the plunge, however, take time to consider all the options, then decide which one is best for you.

Integrated health-care organizations have become such a popular topic that the OSMA has its own traveling show. OSMA attorneys Deborah Bahnsen, Katrina English and Nancy Gillette have taken to the road, assisting Ohio physicians in understanding the new health-care market.

In addition, the OSMA, along with the American Medical Association and the American Group Practice Association, recently held a full-day program to deal with physician-hospital integration.

Most physicians are familiar with the different forms of integration mainly because they've been bombarded with options from various hospital groups all claiming to have *the* solution for them. According to Bahnsen there is no *one* solution. "Physicians need to do their homework. They need to determine what's right for them and for their community," she says.

INTEGRATION IS OPTION

It's no secret conventional medical practices are in distress. To survive in today's health-care market, many physicians may be forced to give up some autonomy in exchange for a measure of control. Physicians may wish to

consider integration of some or all office functions with either other physicians or with a hospital.

However, integration does not have to be total or complete. It can take many forms. Some forms of partial integration include Physician-Hospital Organizations (PHOs), Clinics Without Walls, Management Service Organizations (MSOs), and Multispecialty Group Practice.

Reasons to join an integrated practice include closer collaboration with other physicians and better service to the community.

- In a PHO many forms of ownership are possible. The goal of the PHO is to provide a mechanism for physicians and hospitals to pursue one or more cooperative ventures designed to improve some aspect of health-care delivery within the community.
- Clinics Without Walls are a collection of medical group practices, professionally and economically integrated, while remaining geographically dispersed. (See the November issue of *OHIO Medicine* page 13.)
- Management Service Organizations are nonmedical practice corporations formed by physicians and other interested parties to consolidate the ad-

ministrative functions of contracting physician practices. In this situation, physicians are provided with some of the benefits of partial integration without actually integrating physicians' practices.

- Multispecialty Group Practice is the provision of health-care services by three or more multispecialty physicians who are formally organized as a

legal entity in which business and clinical facilities, records and personnel are shared. Income from medical services provided by the group are treated as receipts of the group and distributed according to some prearranged plan.

WHY SHOULD I JOIN?

Physicians in solo practice may consider partial or total integration because of the increasing difficulty to "go it on their own." There are a variety of integrated health plans available. Models come in all shapes and sizes. Find the one that suits your needs.

Partial integration, such as a PHO or Clinic Without Walls, help physicians compete in today's market. The integrated entity has

the ability to tailor peer review, utilization management, quality assurance, financial risk-sharing and credentialing efforts for a given purchaser. The entity also provides centralized administrative services for the participants.

Good reasons to join an integrated entity include: closer collaboration with other physicians to further patient care; better services to the community; and the ability to compete more effectively in the health-care market.

An article in the August *American Medical News* listed five key things physicians should seek through vertical integration:

- Equity: if there's something to be owned, doctors want 50%
- Parity at the governing table
- Security: the income physicians see today, they want to see tomorrow
- Increased compensation, reflecting a share in the institutional savings that occur when cost-effective medicine is practiced
- Something for retirement, including both income and equity in the new company.

A group needs to be as strong as possible before negotiating with potential partners, says Bahnsen. Seek competent legal counsel and business consultation before entering into any type of agreement. Contact the OSMA's Department of Legal Services if you'd like a speaker to discuss practice integration. ■

AMA interim meeting set for Dec. 5-8 in New Orleans

When Ohio delegates meet for the American Medical Association's interim meeting in New Orleans Dec. 5-8, more than likely much discussion will be devoted to President Clinton's health-system reform proposal.

While most physicians agree with the president that there is a need to reform the health system and provide affordable health care for all, it's the way Clinton's trying

to accomplish this that has physicians debating.

Another heated topic is likely to be the proposal by Rep. Lane Evans (D-Illinois) that would repeal current law that states that the chief medical director of the Department of Veterans Affairs be a doctor of medicine.

The Ohio delegation brings Resolution 67-93 from its House of Delegates Meeting in May. This

resolution deals with the use of recyclable paper for medical publications. The resolution was adopted by the House of Delegates at this year's Annual Meeting. Now, the Ohio physicians would like to see the AMA encourage publishers of all medical publications to use recyclable paper.

Highlights from the meeting will be included in the January issue of *OHIO Medicine*. ■

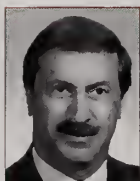
Correction

The November issue of *OHIO Medicine* incorrectly stated that a new publication produced by the OSMA's Department of Educational Services, *CME Opportunities for Physicians*, was sent to all members. The list is available to all OSMA members, but only upon request. To get on the mailing list, contact Janet Orbaker, Department of Educational Services at 1-(800) 766-OSMA. ■

Colleagues

RONALD C. AGRESTA, MD, FACS, Steubenville, was reappointed to a second five-year term with the Ohio State Medical Board

by Gov. George V. Voinovich. Dr. Agresta is chief of staff at St. John Medical Center and health commissioner for Jefferson County.

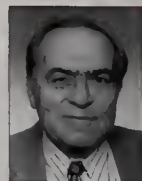


Dr. Agresta

E. DAVID BALLARD II, MD, Evendale, was nominated a black achiever by the YMCA of Greater Cincinnati. Dr. Ballard, who has a private practice in gastroenterology, also serves as an instructor in Bethesda Hospital's family practice residency program.

ROMEO DIAZ, MD, Lorain, received the Health Champion of Northeast Ohio Award from Saint Alexis Hospital Medical Center for his work in breast cancer treatment.

FRED A. ELKUS, MD, Cincinnati, was named medical director for long-term care at Drake Center. Dr. Elkus is a faculty member at the University of Cincinnati College of Medicine.



Dr. Elkus

HARRY FOX, MD, Cincinnati, received the Daniel Drake Humanitarian Award from The Medical Foundation of Cincinnati. Dr. Fox is a clinical professor emeritus of dermatology at the University of Cincinnati.

SUSAN L. HUBBELL, MD, Lima, was elected president of the Academy of Medicine of Lima and Allen County. **E.L. TREMOULIS, MD,** Lima, was elected president-elect.

BENO MICHEL, MD, Cleveland, was elected president-elect, and **MINE KURTAY, MD,** Cleveland, was elected vice-president of the Academy of Medicine of Cleveland.

RICK RICER, MD, Cincinnati, was named Ohio Family Practice Educator of the Year by the Ohio Academy of Family Physicians. Dr. Ricer is predoctoral director for the University of Cincinnati's Department of Family Medicine.

ANN ROGERS, MD, Powell, was named pediatrician of the year by the Ohio Chapter/American Academy of Pediatrics. Dr. Rogers, who is in private practice, also holds an appointment as a clinical associate professor of pediatrics at the Ohio State University.

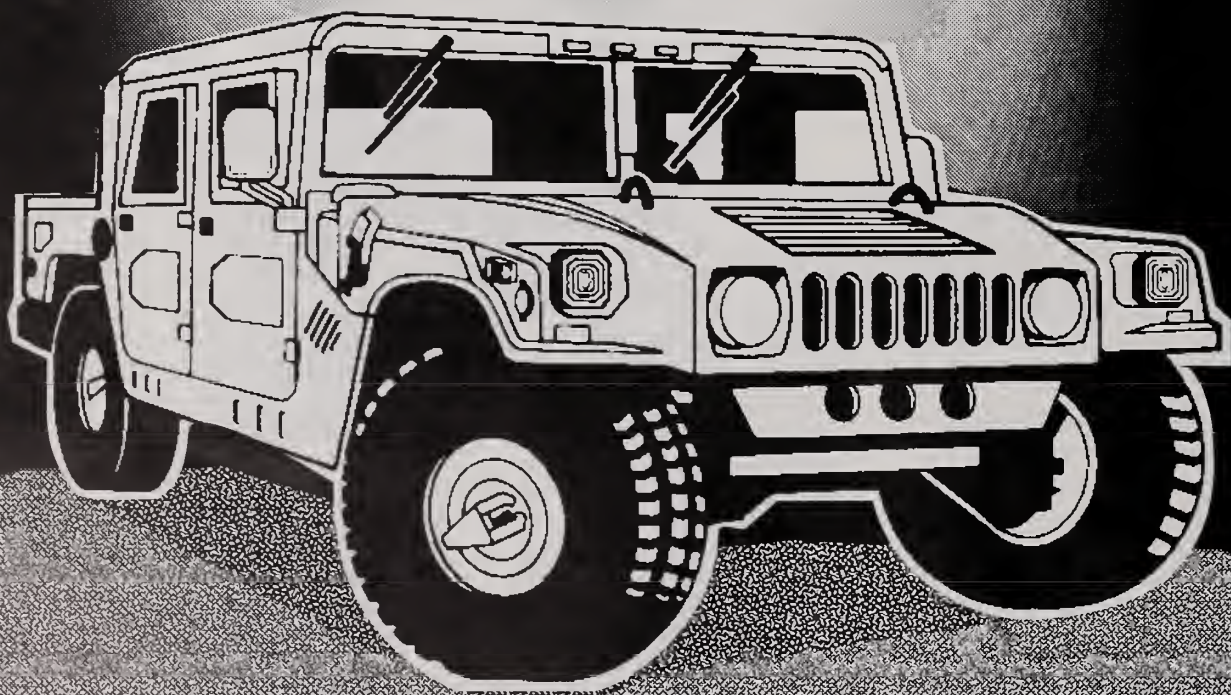


Dr. Rogers

MARY JO WELKER, MD, Columbus, was installed president of the Ohio Academy of Family Physicians; **ROGER D. JENKINS, MD,** Lima, was elected president-elect. Dr. Welker, who chairs the department of family practice at Riverside Methodist Hospitals, is the OSMA's 10th District Councilor. ■

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County medical society notes



Rep. Ralph Regula (R-Canton) briefs Stark County physicians on various health-care reform proposals during a recent Washington fly-in.

■ Stark County

The timing for the fly-in to Washington, D.C., was perfect, according to Nancy Adams, executive director of the Stark County Medical Society. Twenty-two physicians and spouses from the county medical society had an opportunity in October to discuss health-care reform proposals with Ken Thorpe, deputy assistant secretary of Health Policy in the U.S. Department of Health and Human Services, plus talk to Wendall Primus, deputy assistant secretary of Human Services, about welfare reform. The afternoon session included a two-hour discussion with Rep. Fred Grandy on the managed competition act of 1993, which had just passed the day before. The physicians also met with U.S. Rep. Ralph Regula (R-Canton) and U.S. Rep. David Hobson (R-Springfield). The 15-hour day was long but very productive.

A committee of retired physicians recently completed a history of the Stark County Medical Society. "We hope to publish by the first of the year," says Adams. The committee spent two years compiling information. To obtain a copy, contact the society at (216) 492-3333.

■ Cuyahoga County

The Academy of Medicine of Cleveland is on the move. The headquarters recently relocated to offices just minutes from I-77 and Rockside Woods Boulevard. The new home has 10 meeting rooms of varying size, one of which can accommodate up to 200 people for meetings and educational programs. An on-site catering service is also available. The new location will allow the academy to serve the needs of other physician organizations, including almost every specialty society. The academy's new number is (216) 520-1000.

The academy recently cosponsored with Case Western Reserve School of Medicine a program entitled "Should Physician-Assisted Suicide Be Legalized? The object was to promote better understanding of the medical, legal and ethical issues that confront physicians, registered nurses, attorneys, clergy, social workers and other health-related professionals in the debate over physician-assisted suicides.

■ Lucas County

Toledo physicians can attend a CME seminar in Florida March 10-13, offered by the Academy of Medicine of Toledo and Lucas County. The weekend program will provide eight hours of CME credit. Cardiology, dermatology and urology will be the focus. For more details, contact the academy at (419) 473-3200.

Lance Talmage, MD, will be installed as the new president on January 12, succeeding John H. Robinson, MD. As of this writing, the academy

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was trying to firm up a commitment from Sen. John Glenn to speak.

Physicians will once again display their artistic talents at the Second Annual "Physician As Artist" sponsored by the academy and Riverside Hospital. Lynne Mangan, director of communications at the academy, said last year's show was "terrific," drawing hundreds of guests eager to see the paintings, ceramic works and photography done by the many talented local physicians.

The academy has compiled a list of tobacco-free pharmacies in their community and are asking their members to encourage patients to patronize these pharmacies. The academy took the poll in support of the AMA's passage of a resolution urging medical societies to publicly commend tobacco-free pharmacies. ■

Help shape OHIO Medicine in 1994

In order for us to better focus *OHIO Medicine* in 1994, we'd like to ask you to take a few minutes of your time and respond to a brief readership survey inserted elsewhere in this issue.

Should we provide you with more news on OSMA's health-system reform proposals and less coverage on federal proposals? What type of articles and stories do you prefer – question-and-answer, feature-length or the-shorter-the-better? Do you need more legislative news, less legal or vice versa?

This is your opportunity to tell us what you like and don't like about the tabloid publication you receive each month. We want it to be relevant to your practice, and we want to be able to provide you with news you can't get from any other source. Just tell us, on the form, what we need to do to achieve those two goals, then either mail or fax (both sides, please) your responses to us. We'll use your comments and suggestions to help us plan our 1994 issues. Thanks for your time. ■

Group physicians gain more representation

In Brief: The OSMA Council has cleared the way for more group practice representation by allowing the group practice task force to become a committee.

Medical group practices will have a stronger voice in the future at the Ohio State Medical Association, now that the OSMA Council has approved a request from the Group Practice Advisory Task Force to become a standing OSMA committee.

The task force was originally created as an ad hoc advisory group to OSMA's Committee on Membership Marketing. But at a meeting held in late September, task force members indicated that they needed their own committee and greater representation at the OSMA if the association hoped to bring more group practice members into the ranks of organized medicine.

NO BENEFIT PERCEIVED

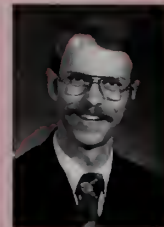
"We used to pay all of our doctors' membership fees," says Robert Coulton, Jr., administrator of professional staff affairs at The Cleveland Clinic Foundation. "Then, several years ago, we gave them a certain amount of money and told them to choose which groups they wanted to join. There was a mass exodus from the OSMA because there was no perceived benefit."

Most of the group physicians and administrators at that meeting agreed that organized medicine in general and the OSMA in particular represent the interests of neither group practice nor managed care, but instead continues to primarily serve the needs of solo practitioners.

"There are certain irreconcilable differences between groups and organized medicine as it exists today," says J. Craig Strafford, MD,

"The OSMA gets credit for recognizing the situation and doing something about it."

- Dr. Strafford



president of the Holzer Clinic and the task force's chair. But as health reform changes the practice of medicine, forcing more and more solo practitioners into groups, then, he asks, who will the OSMA represent?

As Coulton puts it, "Will (health-care reform) eventually require a major shift in the direction of the OSMA?"

To the group practice physicians and administrators who attended the September meeting, a greater voice in organized medicine would be a start, and so the request to become a full committee was made.

CONCERNS EXPRESSED

OSMA's Committee on Membership Marketing was the first to give its approval to the request, but not without discussion on various areas of concern. These included:

- Issues that might separate group practice and solo practitioners
- Increased emphasis on group practices compared to solo practitioners
- Involvement from non-

Continued on next page

OSMA elder abuse campaign to kick off in January

OSMA President Walter Reiling, Jr., MD, and Gov. George Voinovich will headline the January news conference that kicks off the Ohio Physicians' Elder Abuse Prevention Project, the last part of a three-prong approach to family violence sponsored by the OSMA in conjunction with the Department of Human Services. The Department of Aging and AARP will also participate in the news conference.

"Many times health-care professionals ignore signs of elder mistreatment because they are unaware of the extent of the problem or feel uncomfortable about reporting such cases," says Pattye Whisman, MD, chair of the elder abuse task force.

"Our family violence concerns would not be complete if we did not include the elderly," she says. "Elder abuse is an under-recognized area. The task force and OSMA are bringing this issue to the forefront."

The task force and other experts in the field of geriatrics, with the help of the OSMA, produced educational packets to educate Ohio physicians about elder abuse and

mistreatment. By mid-January, more than 6,000 OSMA members will have received their elder abuse packets. This packet contains clinical guidelines, legal considerations and a list of county agencies to which physicians should report suspected cases of elder abuse.

In addition to the packets, a display for physicians' offices will

be available, along with a video and brochures that explain how physicians and spouses can address this issue in their community.

Both residential and group living situations will be addressed. Handbooks are being mailed directly to OSMA members in the following specialties: family and general practice, geriatrics and emergency

medicine. All other OSMA members may order an elder abuse, domestic violence or child abuse handbook free of charge by using the order form that will be in next month's issue of *OHIO Medicine*.

The elder abuse campaign was funded through a \$50,000 grant from the Ohio Department of Human Services. ■

Children's Hospital proposes child abuse center

In last month's issue of *OHIO Medicine*, it was reported that the Ohio League Against Child Abuse was folding due to financial difficulties. The United Way has decided to disburse the funds and services to other agencies in town.

Children's Hospital Guidance Centers will receive \$19,500 remaining from this year's \$74,000 allocation to the League Against Child Abuse. The money will be used to continue programs and for a new center, Center for Excel-

lence in Child Abuse Prevention, which is expected to be a model for abuse-prevention programs nationwide.

Other family counseling services, community centers and Franklin County Children Services may become involved in the planning of the new center.

Catholic Social Services will take over the state's Parents Anonymous Chapter, a group for parents who have taken or have considered taking actions against their children. Catholic Social

Services can direct inquiries to local chapters throughout the state.

Physicians can still obtain materials on the, "Don't Shake A Baby" program and child behavior materials by calling 1-(800) 858-5222.

The Ohio League Against Child Abuse had been listed as a resource in the educational handbook provided by OSMA in conjunction with the Ohio Physician's Child Abuse Prevention Project. ■

physician group practice administrators.

The recommendation to Council from the Committee on Membership Marketing requested that the Group Practice Advisory Task Force become a committee reporting to the OSMA Council, and that the composition of the committee (physician and nonphysician members) remain the same, but with nonphysician members having no official committee voting rights.

Before approving the committee's request, Councilors also expressed some concern about a greater voice for group practice, but decided that, since more physicians are joining groups in anticipation of health-care reform, increased representation for those in group practices was ultimately inevitable.

"Organized medicine was not set up for groups originally," says Doug Evans, director of OSMA's Department of Membership. "But medicine is changing, and we realize we need to look at those changes and whether or not the

OSMA needs to adapt to them."

OTHER STATES' PROGRESS

The State Medical Association of Wisconsin started the process of involving groups in association policy, and Minnesota is already far

ahead of every other state with regard to representation of managed care. The Mayo Clinic in that state, for example, has official representation at the state association level.

The OSMA's move to upgrade the Group Practice Task Force to a

committee may not have reached that stage yet, but group practice members are content with their new position.

"The OSMA gets credit for recognizing the situation and for doing something about it," says Dr. Strafford. ■

Violence project takes top honors

The Ohio Physicians' Domestic Violence Prevention Project was voted to the "A List" – a list reserved for association executives who have achieved excellence in the field of association communications by the American Society of Association Executives.

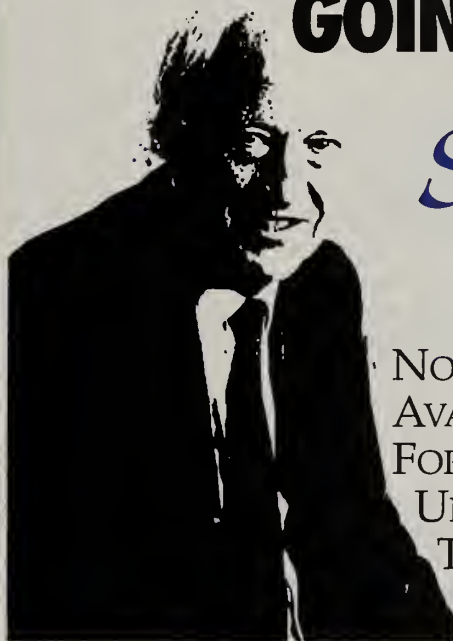
The OSMA will receive a Gold Circle Award of Excellence at the opening session of the conference on Dec. 5 at the New York Hilton in New York City. In addition, the OSMA's winning entry will be on display during the ASAE's 11th management conference Dec. 5-8.

So that other colleagues can benefit from OSMA's expertise, the award-winning entry will be showcased in the 1993 Gold Circle Award Book of Winners. The book will feature a photograph of the entry and a brief summary of its outstanding qualities.

The domestic violence project also received a Silver Quill award at the district conference of the International Association of Business Communicators held in Cleveland in November. ■

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What physicians should do if patient records are destroyed

In Brief: It doesn't take a natural disaster to wipe out years of painstaking record keeping. Even a sprinkler system gone awry can cause irreparable damage to your medical records. Here's what to do if the unthinkable happens.

What would you do if a fire or flood destroyed your medical records? Many physicians along the Mississippi River found out firsthand this summer when flooding destroyed many critical medical documents. The same scenarios are true for the fires in California and the hurricanes in Florida. However, it doesn't have to be a national disaster. A fire in a

private office or a sprinkler system gone awry can destroy years of documentation

and take weeks to reconstruct.

"Probably the best suggestion is to have a master list with the names, addresses and phone numbers of patients," says Bill Todd, attorney with Squires, Sanders and Dempsey in Columbus. "This gives the physician some sort of backup and a way of rebuilding the files in case of a disaster," he says. "The list should be kept in a secure place away from the records themselves." If patient information is on a computer, a back-up disk is a must.

If the records are destroyed the physician should make a note as to how and when the records were destroyed. This is helpful if a phy-

sician is ever brought up in a malpractice claim.

Also, immediately notify the patient that his/her records have been destroyed. This protects the physician in case he or she is ever sued and asked to produce the patient's records.

RECONSTRUCTING FILES

Then, reconstruct the medical records as soon as possible. It's a good idea to conduct a thorough medical history with the patient on his or her next office visit.

Another way to rebuild the patient's file, or part of it, is through insurance companies. Prue Gould, chief underwriter at American Physician's Life, says insurance companies many times have an attending physician's report on a particular insured that was gathered for insurance reasons. These reports vary from a simple summary to a 50-page conclusive report. APL's policy is to make copies, free of charge, upon request of the insured and send copies of the medical record to the physician.

Fellow physicians may have portions of the patient's record if he or she was seen by a specialist or had surgery recently. Pieces of the file could be put together by contacting those physicians.

Hospitals can help, too, according to Cristi Berry, director of medical record service at Riverside Hospital in Columbus. Since Riverside keeps records for 20 years, the chances of piecing together a patient's file is pretty good.

Probably the best idea is to plan ahead. "When designing or looking at a record storage area, take pre-

When Records Are Destroyed:

- Consult master file
- Immediately notify patient
- Begin reconstructing medical history with patient's help
- Contact insurance companies for any history on patient
- Contact fellow physicians who may have information on patient

cautions – think fire-resistant cabinets and/or install a sprinkler system," says Todd. Riverside Hospital has a master patient index at an off-site location that is fire-proof and floodproof.

SHOULD OLD RECORDS BE KEPT?

Unfortunately, some old files are destroyed simply because the physician doesn't think they are necessary. Many physicians are unsure how long to hold on to medical records. According to Katrina English, OSMA's director of the Department of Legal Services, the original medical records should be maintained for an indefinite period of time. This indefinite period can end at least two years after the death of the patient or physician's death. It is extremely unlikely that a medical claim would be successful more than one year after the death of the patient or the doctor. The American Medical Association suggests physicians keep charts for five to seven years from the patient's last office visit.

Ohio's statute of limitations for filing professional medical liability claims has been expanded by several Ohio Supreme Court cases. The Ohio Supreme Court says that the one-year statute of limitations

in Ohio does not begin to run until one year after the physician/patient relationship for the particular illness or injury ends, or one year after the patient should have reasonably discovered the injury allegedly caused by the physician's treatment.

If you are unwilling to incur the expense of storing or microfilming inactive records, at least maintain each record until there is no chance you would have to produce it in connection with a legal or administrative matter.

Some physicians opt to store charts at home or in rented outside space. If you elect to store rather than use microfilm, be sure the records are located in a safe and secure area. There are many fire-proof warehouses available that have a 24-hour policy – meaning that if you need the record they will locate it within a day. ■

New rule means more training for first assistant nurses

Nurses who serve as first assistants in surgery must now meet certain criteria, including 32 hours of specialized training. The new rule, which became effective October 1, was promulgated by the Ohio Board of Nursing and contains no provision to grandfather those nurses who may have performed as first assistants for

years, yet who may now lack the necessary training and credentials.

The Ohio State Medical Association is currently polling those specialties affected by the new rule for their opinion of its impact on their profession. So far, those most troubled by the new rule are those physicians and surgeons in rural areas and smaller communi-

ties where the number of qualified nurses is not as great as in the state's urban centers. The OSMA is also investigating to see whether or not it should work with the Ohio Hospital Association to establish educational programs for those in rural counties who want to be first assistants.

Although there have been some

comment raised about the new rule affecting the practice of medicine since it gives surgeons a smaller pool of qualified people from which to choose their first assistants, it is unlikely that the rule will be appealed.

OHIO Medicine will keep you posted on any further developments. ■

Consumer group ranks Ohio 19th in disciplining doctors

The Public Citizen Health Research Group has ranked Ohio 19th among states for its toughness on disciplining doctors, up from 23rd the previous year.

The state with the highest was Oklahoma with 12.14 per 1,000, and the lowest was Delaware with 0.65 per 1,000.

Ohio took 105 disciplinary actions against physicians in 1992, which averaged 4.25 serious actions per 1,000 doctors. The national average is 3.17 per 1,000 doctors. These figures are part of a two-volume list of 10,289 "questionable doctors" that states and federal government have disciplined since 1986. Public Citizen, a Ralph Nader-founded group, offers a report for \$15 listing the names of these doctors, however the book doesn't provide details of each case.

Dr. Sidney Wolfe, the consumer group's director, was quoted in an Associated Press article as saying that "government agencies catch too few bad doctors, and too many of the ones they do catch are getting away with slaps on the wrist."

In the past six years, Ohio reported 623 disciplinary actions against physicians.

Of the 215 Ohio cases where a specific offense was listed, 46 in-

involved a criminal conviction; 32 drug/alcohol abuse; 27 misprescribing or overprescribing drugs; nine for substandard care, incompetence or negligence; and three for sexual abuse or sexual misconduct.

The remainder were listed under "other offenses."

The American Medical Association has criticized the publication. "It lumps technical violations with serious ones," said Kirk B. Johnson,

AMA's general counsel, in the AP article, although he did agree that the public is entitled to know about problems physicians have that can affect their care. ■

"Guide to Ohio Law" still available

Copies of the fifth edition of the "Physician's Guide to Ohio Law" were mailed in November to members who had requested a free copy. If you forgot to mail in your card, which was included in the September issue of *OHIO Medicine*, it's not too late to call the OSMA's Department of Legal Services at 1-(800) 766-OSMA. Almost 1,000 requests have already been filled.

The first copy is free to OSMA members. Additional copies are \$25 for members, and \$50 for non-members.

The fifth edition of the guide is more user-friendly. The new edition arranges the laws into sections rather than alphabetically.

This guide alerts physicians to Ohio laws that affect various aspects of their practice. ■

The Merits of Membership:



WE CAN MAKE YOUR HEALTH INSURANCE HAPPEN.

Physicians are ineligible for 85% of the health insurance plans on the market today. However, we have a database of health insurance carriers that identifies which plans cover physicians.

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For more information, call John Mayer at 1-800-766-OSMA

OSMA files briefs in Supreme Court cases

In Brief: In one case, a favorable decision for the plaintiff would severely limit physicians' autonomy in treating patients in a hospital.

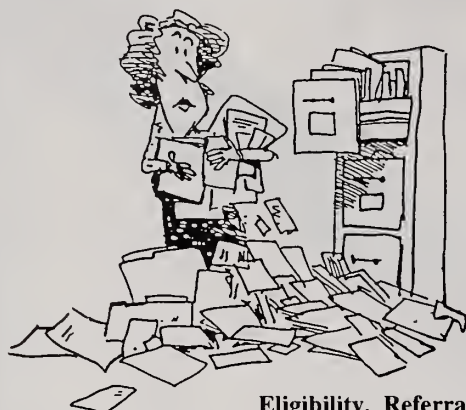
The OSMA has agreed to enter into two legal cases pending before the Ohio Supreme Court. The Legal Department plans to file briefs as amicus curiae, or friend of the

court. Both cases could have significant impact on our members.

The first, known as *Petratos v. Markakis*, involves Lakewood Hospital in Lakewood, Ohio. The issue

is whether a hospital has a duty to monitor and intervene into care rendered by a private physician who has privileges at the hospital. In this case, the plaintiff alleged that he suffered injuries as result of malpractice committed by private physicians who were members of the hospital medical staff. The plaintiff argued that the hospital was aware of the alleged problems with the medical care and should have intervened to prevent his injuries.

The plaintiff is appealing trial court and appeals court decisions in favor of the hospital. The lower court decisions were based on a 1990 case called *Albain v. Flower Hospital*, which held that a hospital has no duty to supervise or second-guess the care rendered by competent physicians to whom it has granted privileges. If the Supreme Court rules in favor of the plaintiff, the decision could severely limit



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What Ohio Physicians Need to Know

Two legal cases before the Ohio Supreme Court affect the medical profession:

PETRATROS V. MARKAKIS

Issue: Does a hospital have a duty to monitor and intervene into care rendered by a private physician who has privileges at the hospital?

At stake: A favorable decision for the plaintiff could limit physicians' autonomy, interfere with the physician-patient relationship, and deter physicians from participating in elected administrative roles within a hospital.

DELLENBACH V. ROBINSON

Issue: Can a defendant-physician in a malpractice case use relevant medical history and records of a patient as evidence?

At stake: Tort reform measures, advanced in the 1980s, that waive "privileged information" disclaimers in malpractice cases.

physicians' autonomy, interfere with the physician-patient relationship and deter physicians from participating in elected administrative roles within hospitals. The OSMA's amicus brief will urge the court to uphold the Albain decision.

The second case in which the OSMA plans to file an amicus brief is *Dellenbach v. Robinson*. This is a malpractice case that impacts tort reform measures advanced in the 1980s. This is a Cleveland-area case in which the appeals court overturned a verdict in favor of the

At issue is whether hospitals have a duty to monitor doctors.

defendant-physician based on the plaintiff's argument that prior medical history had improperly been considered by the trial court. The plaintiff claimed emotional injury as a result of the physician's treatment. The physician was able to win the case by showing that the patient had a prior medical history of emotional problems before he treated her.

Ohio Revised Code section 2317.02 provides that a patient waives the privilege preventing testimony by treating physicians when a malpractice action is filed. Filing of a malpractice claim waives the privilege for communications and records that are historically and causally related to the injuries that are relevant to the issues in the malpractice claim. Generally, rules of court prevent the discovery and presentation of privileged information in lawsuits. However, this law provides a specific exception for malpractice cases.

The Court of Appeals determined that the rule of court preventing discovery and presentation of privileged information outweighed the statute, which provides an exception to the rule. The OSMA believes that the Court of Appeals decision is in error and will file an amicus brief stating our position. The brief will ask the Supreme Court to uphold this important tort reform measure. ■

OSMA files complaint with medical board

The OSMA and several physicians have filed complaints with the medical board concerning services that offer diagnostic tests performed by nonphysician personnel. The test results are sent out-of-state

to be interpreted by physicians.

The concern of the OSMA and other complainants is that the non-physician personnel are performing tests that fall solely within the scope of practice for doctors. If

you are aware of any such services please notify the OSMA Department of Legal Services at 1-(800) 766-OSMA so that we may notify the medical board. ■

The Merits of Membership:



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With the financial changes that are occurring in the medical community, it has become even more important to have your financial situation objectively reviewed.

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For more information, call John Mayer at 1-800-766-OSMA

BWC examining "inequitable" fees

The Ombudsman staff continues to hear complaints from physicians who object to the agency reducing its provider fees.

As reported in the September issue of *OHIO Medicine*, the agency implemented a revised fee schedule on April 1. Shortly after, Claire Wolfe, MD, OSMA's president elect, wrote Wes Trimble, the bureau's CEO, to oppose the revised fee schedule for reimbursement of physician services.

Trimble answered that if physicians could give examples that the BWC's reimbursement is out of line with other payors' payment levels, the agency would examine procedure codes and reevaluate its payment levels.

"If your member physicians identify an individual procedure

code for which the fee maximum is disproportionate to the payment levels of other insurers/payors, we will be happy to review the matter," Trimble wrote.

Physicians who have identified a particular reimbursement as disproportionate to payment levels paid by other insurers should send such examples to the OSMA's Ombudsman Department, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

Physicians should include the CPT code, current BWC reimbursement, amount currently paid by the other insurer and identification of that insurer. All information will be compiled by the OSMA's Task Force on Workers' Compensation and forwarded to the BWC. ■

Western Ohio, PHP to merge

Western Ohio Health Care Corporation, Dayton's largest health maintenance organization, has announced its plan to merge with its sister company in Columbus, PHP Benefit Systems.

Both HMOs have filed with the Ohio Department of Insurance to operate under a single license, although each company will operate

at its present location and use its current name. The combined company name will be United HealthCare of Ohio. United HealthCare Corp. of Minneapolis owns both HMOs.

An estimated 6,000 physicians will be involved with the new, combined company. ■

Bureau unveils "provider assignment"

In an effort to better serve its health-care providers, the Bureau of Workers' Compensation (BWC) has made several changes to its Provider Affairs department.

First, the agency has begun provider assignment, a program that matches physicians with a BWC representative. The representative not only will coordinate the provider's overall service needs, but will also act as a liaison when a provider has a problem with medical fee bills that needs to be resolved.

Physicians who treat BWC patients should have recently received a letter from their assigned representative explaining the program, along with his or her direct telephone number.

The other change the BWC has made is to reorganize its Provider Affairs department into 22 teams – 19 of which are assigned to providers. The other three teams are

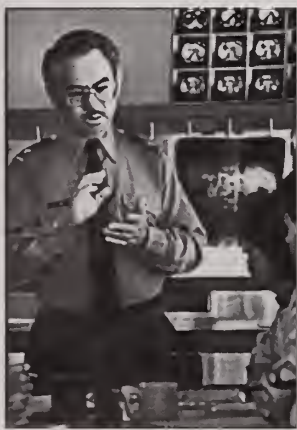
responsible for the following:

- **Sort** – Distributes the 17,000-18,000 fee bills that arrive daily and handles miscellaneous correspondence.
- **Enrollment** – Enrolls new providers.
- **Support** – Offers provider education, training and technical assistance to providers, as well as other BWC offices.

Finally, the agency has decentralized its Provider Affairs Hotline and now employs automatic call distribution and a menu system. By doing so, providers now have quicker access to all 19 teams, each of which has eight staff members who can answer physicians' questions.

For more information, contact the BWC at (614) 466-0141 or 1-(800) 686-1550. ■

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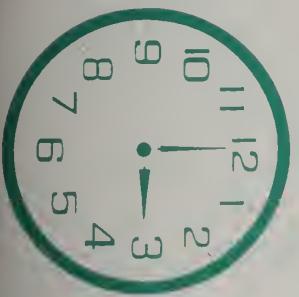
Do you have a problem with a third-party payor that needs to be resolved? Or a question about Medicare? Or a question about CPT or ICD-9-CM?

Chances are, the OSMA's Ombudsman Department can help. Created in 1982, the department has since helped resolve the concerns of thousands of members with third-party conflicts. Some of the areas where the Ombudsman staff can help include:

- Medicare/Medicaid
- Workers' Compensation
- Third-party carriers

- Peer Review Organizations
- Carrier audits
- Coding issues – diagnoses and procedures
- Policy issues

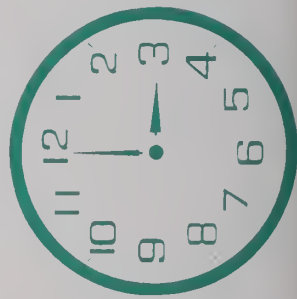
Not only is the staff of the Ombudsman Department able to answer most questions over the phone, but best of all, this service is offered free of charge to OSMA members. If you have a question, concern or idea, we encourage you to contact the Ombudsman staff at 1-(800) 766-OSMA. ■



May We Have a Moment of Your Time?

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Help us make *OHIO Medicine* even better in 1994!





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OSMA Proposal Goes National

OSMA President Walter A. Reiling, MD, outlines the OSMA's proposal for health-system reform to a reporter from the Medical News Network. The interview was held October 11. Medical News Network is a televised program that is shown in the offices of physician-subscribers nationwide.

Cincy hospitals tackle youth violence

Homicide is now the second leading cause of death among young people, ages 15 to 24, surpassed only by car accidents. So, does that make violence a public health issue? While the debate among medical professionals continues, at least two Cincinnati hospitals are taking matters into their own hands.

At University Hospitals, a program called "Chances and Choices" sends experts into schools to talk to students about guns and violence. Because young people tend to feel immortal, "We emphasize serious injury more than death – what a bullet can do to the human body, what life is like as a paralyzed person," says Barbara Drummond, trauma coordinator at University Hospitals.

In addition to giving pointers on

the safe handling of firearms, Drummond urges students not to bring guns to school. Even in suburban districts, guns have become status symbols that can quickly turn deadly in an argument. Says Drummond, "We tell students there are better ways to handle their disagreements."

Trauma personnel at Children's Hospital Medical Center also advise young victims and their families on ways to avoid tragedies, like the 18 gunshot wounds treated there last year. The counseling is given one-on-one.

However, "We are hoping to expand this effort to reach more people before an injury occurs," says Kathy Clark, injury prevention coordinator at Children's. ■

– Susan Porter

Several factors contribute to temporary shortage of Ritalin

Editor's note: William B. Rogers, a pediatrician from Cuyahoga Falls and a member of the OHIO Medicine Advisory Committee, was concerned about a recent shortage of the drug methylphenidate (Ritalin). He wrote to his congressional representative, Thomas C. Sawyer, for an explanation. What follows is the reply that Dr. Rogers received.

BACKGROUND

Although Ritalin is a mild central nervous system stimulant, it does have potential for abuse. As such, it is regulated under the Controlled Substances Act of 1970 and classified as Schedule I or II substance under this legislation. The act requires the Attorney General to set production quotas for these drugs each year. These production quotas are intended to provide an adequate supply of a substance to meet the following year's medical needs.

The process for setting these quotas begins with the Drug Enforcement Agency (DEA) publishing proposed production quotas in the *Federal Register*. After the initial production quota is published, a public comment period ensues. All interested persons, including the public and manufacturers, are in-

vited to respond. The production quotas are then revised, if necessary, and sent to the appropriate agency for review. Once approval is granted, the final production quotas are published.

INITIAL QUOTA REVISED

The initial proposed production quota for methylphenidate for 1993, three million grams, was published on September 22, 1992. The revised production quotas were completed on May 13, 1993. These estimates were forwarded to the appropriate agencies, the Department of Justice and the Office of Management and Budget for review.

For unexplained reasons, this review process took more than two months to complete.

The proposed revised production quota, which was raised to four million grams, was not published until July 27, 1993. CIBA-GEIGY Corporation and MD Pharmaceutical, Inc., two manufacturers of this drug, informed the DEA that the revised 1993 production quota was insufficient to meet all the medical and scientific needs for this drug. The DEA then revised the quota to five million grams.

REASONS FOR SHORTAGES

According to the DEA, temporary shortages of the drug Ritalin may occur or may have occurred already. A number of contributing factors may be responsible for this spot-shortage. First, the entire 1993 production quota was allowed to be manufactured at the start of the year rather than releasing a portion of the quota to begin with, and then allowing manufacturers to apply for additional production later in the year. Another unanticipated event occurred when CIBA-GEIGY notified the DEA in September that the company had reason to destroy a 200-kilogram Ritalin batch. CIBA-GEIGY, however, asked for immediate replacement authority, which the DEA granted. It remains unclear whether the time lapse between the batch destruction and applying for replacement has contributed signifi-

cantly to any shortfall in the drug's availability. Finally, the start of a new school year often coincides with a sharp upsurge in demand for a drug like Ritalin. Since many physicians recommend that the use of the drug be periodically discontinued, summer is usually an opportune time for children to suspend their therapy.

SUPPLIES BEING MONITORED

At this point, it's unclear if the production quota of five million grams will be sufficient to meet all the demand for Ritalin through 1993. If it is not, the DEA has the authority to further revise the 1993 production quota. CIBA-GEIGY and MD Pharmaceutical are monitoring supplies of methylphenidate closely and are prepared to request an increase in the present production limit should further shortages develop. ■

Why Supplies of Ritalin Are Low

- Entire 1993 production quota was manufactured at start of year, rather than releasing a portion of the quota and allowing manufacturers to apply for additional production.
- In September, a 200-kilogram Ritalin batch had to be destroyed.
- Start of a new school year brings sharp upsurge in demand for Ritalin.

Tattoo parlors fall between cracks; statewide regulations proposed

In Brief: Currently, no state agency regulates or licenses tattoo parlors, and until state legislation can be drafted on this issue, local health departments, such as Medina, are writing their own rules.

The August issue of *OHIO Medicine* reported that no state agency currently regulates or licenses tattoo parlors. Instead, that job is left to city and county health departments, a situation that David Baldwin is trying to change.

Baldwin, the Medina County Health Commissioner, is trying to gain support for a statewide law that would regulate tattoo parlors. Although he has found various representatives in favor of such a law and willing to draft a proposal, no legislation has been written so far.

"Tattoos are becoming more and more popular, and more and more tattoo parlors are opening," said Baldwin in a recent *Cleveland Plain Dealer* article. "We decided it was

"We decided it was time to look at tattoo parlors and come up with some commonsense regulations."

time to look at them and come up with some commonsense regulations."

NEW RULES FOR MEDINA TATTOO PARLORS

So, members of Medina County Board of Health sat down and drafted nine pages of rules. After review by the county prosecutor's office, the regulations passed in late August.

Shop owners say many of the regulations – properly disposing of needles, wearing surgical gloves and keeping parlors sanitary – are

already being followed. However, parlor owners are questioning a few of the new rules, primarily the medical history forms customers will be required to fill out, disclosing any skin conditions they may have – rashes, birthmarks, pimples, skin cancer, etc. – as well as their status regarding HIV or hepatitis B infections. If any of these conditions are found, the regulations say, the customer cannot be given a tattoo.

Baldwin defends the record forms, saying that if someone would get ill for whatever reason, a

record would be available and the appropriate person could be contacted. If a tattoo parlor owner goes out of business, the records become the property of the health department.

On top of the new regulations, tattoo parlor owners will be paying \$200 for an annual permit, and must agree to periodic health inspections.

MOBILE UNITS ARE THE RAGE

Mobile tattoo parlors are becoming very popular, according to Baldwin. The mobile units pull into cities for a few days during special events. He insists the mobile units visiting Medina County will need to follow the same regulations as a permanent location.

"We are interested strictly in the safety and health of the customer who is receiving the tattoo," says Baldwin. "We are not trying to restrict tattoo parlors, however we insist the parlors be safe and sanitary." ■

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NEOUCOM's Doctors Fair matches communities, physicians

The Northeastern Ohio Universities College of Medicine, with the support of the OSMA, launched its first-ever Doctors Fair this past October in an effort to link together communities that need physicians with their medical students and residents.

The event was scheduled around two annual events at the school: a flag football tournament, held between medical students and residents, and an evening recruitment fair for residents. According to Lowell Gerson, who served as chair of the Doctors Fair Committee: "The overwhelming number of participants at the fair were people still in school, using the fair as an exploration to see what opportunities exist in the communities."

What those who attended the fair soon learned was that there is plenty of opportunity out there. Representatives from 20 hospitals attended this first fair, offering stipends, net income guarantees, signing bonuses, loan repayments and other incentives to those physicians who would agree to practice in their community. Commitments requested were commensurate with the package agreed on.

From the student/resident standpoint, then, the fair was a success.

However, hospital representatives expressed some disappointment over the fact that the majority of those who came through the Doctors Fair were medical students rather than residents. The hospitals' need for physicians are immediate, they explained, and they had hoped that the fair might net them some ready prospects in addition to paving the way for future ones.

Fortunately, the evening Residency Fair seemed to alleviate some of the disappointments. Mike Oler, MD, director of the Family Practice Residency Program at St. Elizabeth's Medical Center in Dayton, who represented the hospital at the evening event says, "Feedback has been good. Residents had a chance to talk with several people, and they thought it was worthwhile."

NEOUCOM is already making plans to improve its next Doctors Fair.

"We've asked those hospitals that participated what they thought they might want us to do next year to make it better for them," says Gerson. "As the information comes back we will, I'm sure, make some changes in response to the needs of the hospitals."

— Angela Truglio-Kovalik



Phillip Teague, MD, representing Union Hospital in Dover, and Molly Demuth, vice president of the hospital's Administrative Services, talk with NEOUCOM medical student Mae Oh during the school's recent Doctors Fair.

Recruitment promises prove false

The FBI is investigating a fake recruiter who has allegedly conned rural communities throughout the Midwest — primarily Minnesota, Iowa, Missouri and the Dakotas — by promising to refer doctors to them in exchange for \$2,000. The deal calls for a town to pay the Scottsdale, Arizona-based recruiter another \$15,000-\$18,000 if the physician is hired.

Yet when the \$2,000 is paid, no doctor appears and the recruiter vanishes. Before sending any money to a recruiter, check first to make sure he or she is legitimately attempting to place actual physicians in small-town settings. Or attend recruitment fairs, such as the Doctors' Fair recently held at the Northeastern Ohio Universities College of Medicine. ■



Cancer Survivors' Rally

Breast cancer survivors surround Ohio's First Lady Janet Voinovich at a rally for National Mammography Day held recently in Columbus. At the rally the governor announced a \$2.6 million federal grant to start a breast and cervical cancer early-detection program. The goal is to pay for mammograms and Pap tests for poor women.



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A Who's Who of the Ohio Health Care Board

When House Bill 478, the health-care reform legislation, passed the Ohio General Assembly about this time last year, it created a new, independent board to advise the state on how health-system reform could be best achieved in Ohio.

In April, the 16-member Ohio Health Care Board began to meet, and as

the summer progressed, board members divided into subcommittees so they might better study and review the various factors of health-system reform.

The board is expected to present its recommendations on reform to Gov. George V. Voinovich next month. However, that doesn't mean that the

board will then disband. The Ohio Health Care Board's executive director, Jackie Fullerton, said in an interview with *OHIO Medicine* last April that "The Legislature has given us broad authority, and our mission is very broad." That means, she says, the board will remain in place to serve as the state's chief health-care adviser.

For that reason, *OHIO Medicine* thought you should be introduced to those members (all appointed) who sit on the Ohio Health Care Board. After all, they may well be the individuals who hold your professional future in their hands. The board members are:

Carol Adams Columbus

Appointed by: Senate President Stanley Aronoff (R-Cincinnati)
Represents: Consumer interests
Current position: Member of the Ohio Capital City Task Force of the American Association of Retired Persons



Carol Adams

Darryl F. Allen Maumee

Appointed by: Senate President Stanley Aronoff (R-Cincinnati)
Represents: Interests of employers
Current position: President and chief executive officer of Trinova Corp.



Darryl F. Allen

John "Jack" Burry Cleveland

Appointed by: Gov. George Voinovich
Represents: Interests of insurers
Current position: Chief executive officer of Blue Cross and Blue Shield of Ohio



John "Jack" Burry

John Polk Cleveland

Appointed by: House Speaker Vern Riffe (D-New Boston)
Represents: Interests of employers
Current position: Executive director of the Council of Smaller Enterprises



John Polk

William Porterfield, MD Columbus

Appointed by: Gov. George Voinovich
Represents: Interests of health maintenance organizations
Current position: President and chief executive officer of PHP Benefits



William Porterfield, MD

William Ruse Findlay

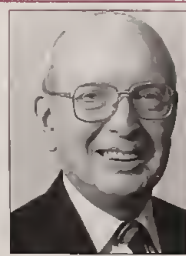
Appointed by: Gov. George Voinovich
Represents: Interests of health-care providers (hospitals)
Current position: President of Blanchard Valley Hospital



William Ruse

Harold Duryee Columbus

Appointed by: House Bill 478 (by position)
Represents: Was not appointed to represent interests of any group
Current position: Director of the Ohio Department of Insurance



Harold Duryee

George Fabe Cincinnati

Appointed by: Senate President Stanley Aronoff (R-Cincinnati)
Represents: Interests of senior citizens
Current position: Former state superintendent of insurance



George Fabe

Robert Farrington Columbus

Appointed by: House Speaker Vern Riffe (D-New Boston)
Represents: Interests of labor
Current position: Secretary-treasurer of the Ohio Trades Council



Robert Farrington

Peter Somani, MD Columbus

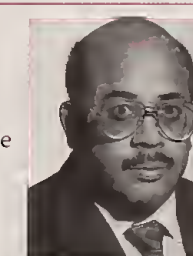
Appointed by: House Bill 478 (by position)
Represents: Was not appointed to represent interests of any group
Current position: Director of the Ohio Department of Health



Peter Somani, MD

Arnold Tompkins Columbus

Appointed by: House Bill 478 (by position)
Represents: Was not appointed to represent interests of any group
Current position: Director of the Ohio Department of Human Services



Arnold Tompkins

Claire Wolfe, MD Columbus

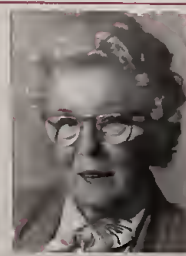
Appointed by: Gov. George Voinovich
Represents: Interests of health-care providers (physicians)
Current position: Physician at Mount Carmel Medical Center, and president-elect of the Ohio State Medical Association



Claire Wolfe, MD

Elsie D. Helsel Athens

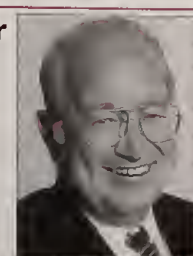
Appointed by: Gov. George Voinovich
Represents: Interests of disabled people
Current position: Chair of the Ohio Developmental Disabilities Planning Council



Elsie D. Helsel

Dwane Houser Cincinnati

Appointed by: House Speaker Vern Riffe (D-New Boston)
Represents: Interests of preferred providers
Current position: Chief executive officer of Community Mutual Insurance Company



Dwane Houser

Frederick James, MD Cincinnati

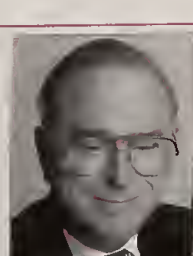
Appointed by: Gov. George Voinovich
Represents: Interests of children
Current position: Professor of pediatrics, Children's Hospital Medical Center



Frederick James, MD

Sidney Zilber Cleveland

Appointed by: House Speaker Vern Riffe (D-New Boston)
Represents: Interests of the consumer
Current position: President of Zilber and Associates



Sidney Zilber

Jacqueline Fullerton Columbus

Position: Executive director
Previous position: Formerly president and chief executive officer of the Health Coalition of Central Ohio



Jacqueline Fullerton

Robert Olexo Columbus

Position: Deputy executive director
Previous position: Formerly a Belmont County commissioner



Robert Olexo

The Ohio Health Care Board has two appointed staff members. They are:

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ALFRED ERB, MD, Fairfax, VA; Hahnemann Medical College of Philadelphia, Philadelphia, PA, 1941; age 79; died September 18, 1993; member OSMA and AMA.

JACK H. PERSINGER, MD, Washington Court House; University of Louisville School of Medicine, Louisville, KY, 1932; age 87; died September 15, 1993; member OSMA and AMA.

GILBERT W. HOPKINS, MD, Dayton; University of Louisville School of Medicine, Louisville, KY, 1960; age 60; died September 30, 1993; member OSMA and AMA.

CARLOS D. RIAN, MD, Massillon; Ohio State University College of Medicine, 1929; age 89; died September 12, 1993; member OSMA and AMA.

SIMON J. ISAAC, MD, South Amherst; Calcutta Medical College, Calcutta University, Calcutta, West Bengal, India, 1944; age 77; died September 2, 1993; member OSMA and AMA.

JOHN W. SCHAUER, MD, Delaware; Rush Medical College, Chicago, IL, 1928; died May 12, 1993; member OSMA and AMA.

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